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COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, November 14, 2012

LEGISLATIVE CHAMBER

Department of Health and Wellness
Cape Breton District Health Authority

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Public Accounts Committee

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[Mr. Eddie Orrell replaced Mr. Chuck Porter]
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Mrs. Darlene Henry
Legislative Committee Clerk

Mr. Jacques Lapointe
Auditor General

Ms. Evangeline Colman-Sadd
Assistant Auditor General

Mr. Terry Spicer
Assistant Auditor General

Mr. Gordon Hebb
Chief Legislative Counsel

WITNESSES

Department of Health and Wellness

Mr. Kevin McNamara,
Deputy Minister

Ms. Suzanne Rhodenizer-Rose,
Director of Health Care Quality and Patient Safety

Ms. Linda Penny,
Chief Financial Officer

Cape Breton District Health Authority

Ms. Dianne Calvert Simms,
CEO

Mr. Jim Merkley,
Vice President of Operations

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, NOVEMBER 14, 2012

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN
Mr. Keith Colwell

VICE-CHAIRMAN
Mr. Howard Epstein

MR. CHAIRMAN: Good morning. I'd like to start the meeting with introductions.

[The committee members and witnesses introduced themselves.]

MR. CHAIRMAN: I'm Keith Colwell, MLA for Preston, and your chairman. I'm going to start this morning with Mr. McNamara's opening remarks and then, following him, we'll go to Ms. Simms with her remarks.

MR. KEVIN MCNAMARA: Thank you very much, Mr. Chairman**.** Good morning. I would like to start by introducing Suzanne Rhodenizer-Rose, our Director of Health Care Quality and Patient Safety, and Linda Penny, our Chief Financial Officer. I also want to acknowledge my colleagues, Dianne Calvert Simms and Jim Merkley, who are making a joint appearance here with us today.

As Deputy Minister of Health and Wellness, nothing is more important to me than the safety of patients who rely on our system for care. We, at the Department of Health and Wellness, take our responsibility for providing leadership and support for quality and patient safety very seriously. We want Nova Scotians to continue to have access to appropriate, coordinated and safe health care that responds to their needs.

Recognizing the importance of good infection prevention and control practices in providing safe care, we created Infection Prevention and Control Nova Scotia in 2009. This small team - which our former minister, the Honourable Maureen MacDonald, described as "punching above its weight class" - has provided leadership, support, and expertise for good infection control practices across Nova Scotia. They have focused largely on building capacity in hospitals and nursing homes through direct support and advice and have also provided education, training, and resources.

We also established a Quality and Patient Safety Advisory Committee to provide advice and make recommendations to our minister on quality and patient safety. This forum of experts has experience and expertise on patient safety and knowledge, and experience in health law and patient safety and other matters that will help promote and inform a provincially coordinated, innovative, and patient-centred approach to quality and patient safety improvement in Nova Scotia.

We have made significant progress, yet we know there's room for improvement. The Auditor General's Report on Infection Prevention and Control at Cape Breton District Health Authority highlighted that the department could be doing a better job of monitoring infection prevention and control practices in Nova Scotia hospitals. We accepted the Auditor General's recommendations and are working hard to strengthen our ability to monitor infection prevention and control practices. I welcome the opportunity to be here today, along with my colleagues from the Cape Breton District Health Authority, to update you on our actions our department has taken to help make the health system safer for Nova Scotians.

As experienced in Cape Breton, a health care-associated infection like C. difficile can have a devastating impact on patients, resulting in longer stays, complications and, unfortunately, in some cases, death. While patient safety is a priority for all district health authorities, infection prevention and control is an ongoing challenge for hospitals. Preventing the spread of infection requires good policies, use of evidence-based practices, and compliance. Unfortunately, a gap in any one of these areas can lead to an outbreak like we saw in Cape Breton.

Former Cape Breton CEO John Malcom acknowledged that breaks in infection prevention and control practices contributed to the outbreak, and made a commitment to learn from this experience. We believe the district has taken that responsibility very seriously. To help us determine the level of compliance in practice and recommendations, our staff made an unannounced visit this summer and saw significant improvements. We will continue to work to ensure the lessons learned from these outbreaks support ongoing improvements in Cape Breton and across our province.

The Department of Health and Wellness invested significant human and financial resources to support Cape Breton in responding to the outbreak. Our Infection Control consultants spent approximately five weeks on-site assisting with tracking, educating staff,

auditing practices, and participating in the outbreak team and decision-making process. They provided a series of recommendations for improvement which were consistent with the Auditor General's own findings. Our leadership team participated in regular calls with the district during the outbreak and continues to provide support and advice to ensure ongoing improvement. In addition, the department has committed $2 million to the Cape Breton District Health Authority to make infrastructure improvements such as additional sinks and flooring repairs. This work is well underway.

Equally importantly, we are working to ensure that patients across Nova Scotia benefit from the lessons learned during the C. difficile outbreak in Cape Breton. We shared our findings and recommendations with all district health authorities. We asked them to take a critical look at their own practices, identify areas for improvement, and put plans in place for meeting the recommendations. This gap analysis is also being used to inform our work with Infection Prevention and Control Nova Scotia. While C. difficile is a reality for all hospitals, we are working together with our district health authorities and the IWK to better prevent and improve our response to outbreaks.

The Auditor General identified the need for a provincial surveillance system for hospital-acquired infections. Although we do not have a formal electronic surveillance system, we are beginning to collect data on a variety of infection control indicators and developing a mechanism for reporting to allow us to monitor and provide oversight. In May the government passed the Patient Safety Act, and this Act will require district health authorities and the IWK to report patient safety indicators publicly and to the Department of Health and Wellness. This will strengthen and support our efforts to improve patient safety and provide greater public accountability to our patients.

Regulations have been drafted to support reporting of two very important patient safety indicators - health care-associated C. difficile rates and hand hygiene adherence - which are considered by many experts to be one of the best ways to measure patient safety overall. These regulations are expected to be approved by the end of this year. Data collection will begin in January, with mandatory reporting beginning in April 2013.

The district health authorities and the IWK monitor and report many patient safety indicators, including infection rates, to their boards, to Accreditation Canada, and to other agencies such as Safer Healthcare Now!, but they are not necessarily reported publicly or to the Department of Health and Wellness, and they're not necessarily reporting indicators in the same way.

In order to collect comparable data for hand hygiene adherence rates, we need to create a formalized structure for monitoring and reporting that clearly describes the types and frequency of audits and reporting we expect. We worked with the districts to develop common collection methods and reporting processes to ensure data can be compared across our province. This will allow us to monitor rates over time, track improvements, and develop strategies to address areas of concern, providing a greater level of oversight.

We have also added C. difficile to the list of notifiable diseases under the Health Protection Act, making all cases reportable by law in Nova Scotia as of April 1, 2012. Reporting is now occurring with outbreaks flagged to the Public Health alert system. This, too, is strengthening our efforts to identify and monitor infection and diseases in Nova Scotia.

We are also working to identify and assess the risk of transmission of infections with infrastructure issues in Nova Scotia's aging hospitals. We have put a team in place who are visiting targeted areas such as sterile processing departments, in-patient rooms, and endoscopy suites in hospitals across our province. They are assessing a variety of factors ranging from the condition of work surfaces and furniture to the availability of hand-washing sinks. This process is enhancing education and awareness and will help the districts and the IWK prioritize infrastructure projects. The project is expected to be completed by January of next year.

To ensure the higher level of accountability and adherence to evidence-based practice, Infection Prevention and Control Nova Scotia has developed a number of best practice guidelines. Guidelines for the management of C. difficile, and a policy on reprocessing of single-use devices will be completed by March 2013. We are also continuing to build leadership and capacity for infection prevention and control at the district level through education, training, and resources. The department recently supported an education session for DHA boards related to the government's responsibility for patient safety.

As indicated by the Auditor General, our Quality and Patient Safety Division, which includes Infection Prevention and Control Nova Scotia, is working with limited staffing resources. This has impacted our ability to achieve all of our objectives as quickly as we would have liked; however, we are making progress and will continue to review our resource needs to determine if additional staff is required. We also need to keep in mind that, as always, requests for additional resources have to be carefully weighed against many competing priorities. Improving patient safety is a priority for all district health authorities and the hospitals they manage, and is a priority for the Department of Health and Wellness. We are working hard to enhance our ability to meet our legislative responsibility, oversee health system quality, strengthen the public's confidence in our system, and enable better and safer patient care for Nova Scotians. Thank you.

MR. CHAIRMAN: Ms. Simms.

MS. DIANNE CALVERT SIMMS: Thank you. I welcome this opportunity to provide an update on Cape Breton District Health Authority's progress on the recommendations contained in the Auditor General's Report on infection prevention and control. This is a time for us to share our district's journey and show how we are transforming the culture of infection prevention and control and patient safety. The initial C. difficile outbreak experienced in our district was truly unfortunate. The C. difficile

strain was extremely virulent, and while our practitioners originally believed we had the number of in-patient cases under control, it quickly became evident that we were facing a different situation.

Before I proceed to the Auditor General's recommendations, it is important for me to note that there is a broader view that must be taken into account when looking at infection prevention and control, including C. difficile. We need to understand not only why the infection occurs but the many elements impacting the cycle of this particular health care-associated infection. A person suffering from C. difficile could be living in the community or in a nursing home or be a hospital patient. They may already have an underlying illness and they may have been exposed to antibiotic treatments or proton inhibitor medications.

The result of a C. difficile infection is an alteration of normal bowel flora, whereby the C. difficile virus produces toxins. The infected individual then exhibits symptoms of tiredness, abdominal pain, and diarrhea, and it is through the diarrhea that the C. difficile spores are shed. C. difficile spores are transferred to others through human-to-human contact and/or human contact with contaminated surfaces such as beds, furniture, bed tables, et cetera.

Breaking the cycle of illness is positively impacted by early diagnosis of the infection, treatment, appropriate use of antibiotics, avoiding the use of proton pump inhibitors, hand hygiene, environmental cleaning, washing of food, effective waste disposal, isolation of hospital in-patients, reducing patient transfers, and reducing in-patient length of stay. As you can appreciate, there is no one big fix, but many things can be done to limit the spread of infection and to prevent outbreaks. This was one of our learnings.

We have not lost sight of what happened in our district. It has been a difficult and life-changing experience for all of us, but none more so than for our patients and their families. Some of our patients who were already seriously ill became sicker, and despite our best efforts, some of those patients died. For that, we are truly sorry.

I will now turn to the Auditor General's Report. As with previous independent reports, we have accepted all of the Auditor General's recommendations and have been providing progress reports to the public, our staff, our colleagues, the Department of Health and Wellness, and the Office of the Auditor General. Our district fully acknowledges the need to improve and strengthen its culture around infection prevention and control. We recognized that this was an issue early in the first outbreak, and efforts to address this were underway prior to the arrival of the Auditor General's team.

Follow-up and action: our response to all the reports and the recommendations may best be put into two categories. The first category would be the one containing the more technical elements, like environmental cleaning, hand hygiene, education and process

change, and technology changes. We've made significant progress in these areas, as evidenced in the supporting documentation provided to the committee. Out of 20 recommendations made by the Auditor General's review team, 70 per cent have been met. The remaining 30 per cent, or six recommendations, continue as a work in progress. We expect these to be completed by the end of December.

Examples completed to date include: our number of infection prevention and control practitioners has been increased and the service is being reorganized in order to be more effective. We've implemented an in-patient management checklist that is completed daily and which supports our infection prevention and control practitioners in their work endeavours. We've moved from a paper-based health care-associated infection reporting system to an electronic database. This has freed up our practitioners to be out on the units conducting daily surveillance and education activities.

We've moved to real-time electronic hand hygiene auditing system, enabling us to provide immediate feedback to staff; results are then posted on the units. We've removed paper and cork boards from our units, repaired damaged surfaces, purchased new equipment, installed sinks where none existed, cleaned our supply rooms, removed spray wands from most of our utility rooms and renovated patient areas to ensure that we meet current infection prevention and control standards. But there is still work to be done.

We've introduced an anti-microbial stewardship program. This is a program to help with the reduction and improved use of antibiotics for in-patients. We've changed our cleaning products and practices and, along with other health care organizations, we are now considering switching to another cleaning product and process. This is all part of our ongoing learning.

The second category covers an area where we build a culture in which everyone - health care providers, the public, patients and their families - take ownership and responsibility for infection prevention and control. If there is one thing that we have learned beyond all others is that infection prevention and control is everyone's responsibility.

Since the first outbreak we know that there are still times that infection prevention and control practices are not being applied routinely or consistently. As an organization we must understand why, what the barriers are, and how we as leaders can encourage, promote and support adoption of safe infection prevention and control practices, every time. Our work on making the culture stronger with consistent adoption of measures is ongoing, it will not stop.

We have sought outside help. In September we hosted Dr. Michael Gardam and his colleague Leah Gitterman, an epidemiologist, both are with the University Health Network in Toronto and they are considered Canada's leading health authority on infection prevention and control. These individuals met locally with health care providers and also

with our board, staff, physicians, and people from our communities to share their knowledge, expertise, advice and opinions in relation to infection prevention and control and C. difficile. We are also pleased to note that on June 1, 2012 our organization received notification that we were accredited with exemplary standing from Accreditation Canada and we were commended on our response to the C. difficile outbreak.

In summary, the anatomy of an outbreak is certainly complex. There are many factors at play and the various elements are interrelated. Addressing the challenges of infection prevention and control and safety involves planning, teamwork, education, and changes in the way we do some of the work and how we deliver hands-on care. It also takes an individual awareness and a commitment to patient safety by everyone. This cannot be done in isolation; it involves leadership, co-operation and partnerships.

We must thank our partners in other districts for sending help and being there when we needed support. There was no hesitation when the calls were made. There was no hesitation, in terms of the infection prevention and control practitioners from those districts. They were on the ground in Cape Breton in a matter of hours, when we had the first outbreak. The mutual aid approach is alive and well in health care across this province and will only get better based on our experience with C. difficile. The Department of Health and Wellness, the minister, the deputy minister, and the technical team, including my colleagues from Infection Prevention and Control Nova Scotia, provided advice, expertise and significant financial support that continues to this day.

Lastly we have not lost sight of what happened in our district. We regret the situation and, while deeply sorry, the lessons learned must inform what we do every day as we continue to deliver safe, appropriate and quality care into the future. It is a lesson for our district, it is a lesson for other districts in this province, and a lesson for every health care system across this country.

Thank you for your time and for the interest in our journey as we work toward enhancing infection prevention and control and patient safety. We'd be pleased to respond to any questions.

MR. CHAIRMAN: Thank you. Mr. Younger.

MR. ANDREW YOUNGER: Thank you to the presenters. This is obviously a very serious issue and I recognize right off the bat that there have been some improvements, or there appear to be some improvements. I think we need to recognize that this is something which affects a lot of people, and potentially affects a lot of people - in fact, any consumer of health services in the province.

A number of years ago, my grandmother actually got a MRSA, which is a hospital-acquired infection – not in Nova Scotia, so you don't have to worry, I'm not going to ask about that. It was in the U.K. and it was telling how differently the infection

protocols were handled there - and I was there at the time - than they appeared to have been handled in the Cape Breton district.

I don't pretend to be an expert in it but I have read through much of the documentation that has been provided by the Department of Health and Wellness in terms of the protocols, which they have now adopted or are in the process of implementing. One of the things that troubles me is the fact that many of those protocols were protocols that, in 2005 I was watching being implemented and already were the standard protocols in the U.K. when my grandmother got that infection.

Many of these, as some people have noted to me, are effectively off-the-shelf protocols that have been well known for a long time. That's not to suggest they're the wrong things to adopt because obviously they are the standards, and I think in your remarks you noted that they are the standards, but what troubles me is that, in some cases at least, those have been the standards for a long time and I think it begs the question as to why those standards were not in place before we ended up with the situation we did in 2011.

I am not naive enough to believe that, with any protocol, you would never have an infection in a hospital. Let's face it, people in hospitals are in hospitals because they are sick and there are infections in hospitals, but what appears to be the case here, in reading through the auditor's report and the reports of this, is that there was - and I guess it remains to be seen whether there still is - a culture of a lackadaisical attitude towards infection control. I'm concerned about whether that has continued, in part because in May of this year the government introduced a bill around hand washing. I'm not convinced that a bill was necessary to go ahead with it, but that's fine. I think it could have been done without the bill. I hear from the deputy minister that the regulations are still not in place for that and yet I would have felt that this was an extremely serious issue.

As well, I think I heard the deputy minister talk about the request for resources against priorities. That's something I'm going to want to get to a little bit later because I think there are a lot of people - family members of people who are sick and especially family members of those who died - who will be very disturbed to think that a request for resources to deal with a culture of infection and problems in the hospital system is being held up in a department, or potentially held up, based on a competition for resources. My initial reaction was that it strikes me this should float to the top because people die when that doesn't get addressed.

There are some things that we can sit around and we can talk about - should you spend on this or should you spend money on that - that's a fair debate and that's a policy debate between political Parties and different ministers. I would be surprised if anybody would argue that a situation where resources could prevent somebody from dying would be something that would qualify as something where it should be balanced against other priorities because when they're dead, they're dead. If there is something that we could have done to prevent that, then I think that is a problem. I want to address those over my

questions now and questions going forward because I'm happy and I recognize that there are things that have been done, but I think we need to know why some of the stuff wasn't done in the first place. I also think there are things in the remarks that maybe I misunderstood in the opening remarks that also trouble me.

I don't often do this but I want to start with the auditors, a couple of questions for the auditors just to understand some of this, but those are the issues that I hope to get to today. When the auditors went to Cape Breton and you talked about your work from April 2009 until June 2011 - you actually ended up in the authority during one of these outbreaks. I'm just wondering, were there issues identified that were so urgent at the time that your office felt you couldn't wait until the report came out, you had to bring those to the attention of the health authority to be addressed immediately, and if so, what were those?

MR. JACQUES LAPOINTE: Since we have Evangeline Colman-Sadd with us, who was in charge of the audit at the time, I'll ask her to directly address your question.

MS. EVANGELINE COLMAN-SADD: Thank you. During our audit, certainly there were issues that we identified that were concerning to us. I can't say there was anything we identified that we thought sort of had to be brought to the district's attention immediately, outside of the normal audit process which, for example, when we were doing scope testing and we had issues with finding adequate evidence of cleaning and disinfecting of scopes between patients, that's something that as part of a normal audit process would get addressed with staff right away because you can't find the evidence.

Outside of that, I would say that certainly my understanding from our discussions with staff in Infection Prevention and Control at the Department of Health and Wellness was that they had a fairly good understanding from the first outbreak, of things that were lacking at Cape Breton District Health Authority and had been making efforts with the district to make sure the district was aware of those. So those things did come up during our audit, but I would have seen the department at that point as having already provided some guidance in those areas.

MR. YOUNGER: Okay, so it was primarily around paperwork or records issues and where you just needed to find - we don't see the evidence that this was cleaned, do you have something that shows this?

MS. COLMAN-SADD: I think with the paperwork, it is important to note that in those instances there was no evidence those scopes were cleaned and disinfected so I don't want it to sound like the paperwork was over here instead of over here and you just had to find it. It was very, very difficult and it would have been very difficult for the staff involved to know those were clean.

One area, though, that I guess does come to mind that is in the report that our staff did bring to staff's attention at Cape Breton was the issue of a patient who was in a room,

on isolation measures, due to either actual or suspected C. difficile, and our staff observed that patient leave her room in a wheelchair and proceed to a common area of the hospital. Our staff were quite concerned by that because our understanding is that furniture and pieces of equipment and whatnot from the room, as well as the patient herself, could be contaminated with C. difficile and could then contaminate other surfaces or patients. So we did bring that to the attention of the nursing staff on the unit at Cape Breton District Health Authority at that time, and as our report indicates, were quite concerned by the staff's reaction to that particular incident. They made sure the patient had a gown on and I believe a mask, but allowed her to continue in the wheelchair from her room, which was not appropriate.

When we discussed that with senior staff, some concerns were expressed about whether or not hospitals could prevent patients from wandering through common areas. I guess my opinion on that would be that hospitals put patients on isolation measures all the time, for a variety of reasons.

MR. YOUNGER: I would agree with you. Do you recall what the dates would have been that you were actually touring the hospital facilities?

MS. COLMAN-SADD: I can give you our rough fieldwork dates: we would have arrived in Cape Breton for fieldwork in early September and would have been there throughout some point in October. There was a point at which some accreditation work was going on and we were trying to sort of get out of their hair while they were dealing with accreditors and whatnot, too, so we may have kind of left for a week or two and then come back towards the end of October. I can't remember the exact dates but it would have been those couple of months that would have been the bulk of our fieldwork.

MR. YOUNGER: You indicated some concern about the hospital administration and the nursing staff when you brought that particular issue to their attention, have you noticed a change of attitude since? I mean I know you're not in the district health authority there now, but in response to your report.

MR. JACQUES LAPOINTE: I can speak to that. I would say I have noticed a change of attitude. At the time when we were clearing the report and discussing it with senior management, my feeling was that management was quite defensive and was having difficulty accepting a lot of the things that we were saying and since then what I see is more of an acceptance of the facts and acceptance of the need for change. So I do see a change from the time we were in there.

MR. YOUNGER: That's good to hear. You had indicated in your briefing last week that when you were touring the facilities in Cape Breton, there were signs that talked about changes being implemented on a temporary basis. I just wondered if you could maybe elaborate or speak to that?

MS. COLMAN-SADD: Those signs would be things, for example, a sign posted that says until further notice x/x is to be done and these were common infection and prevention control practices that you would have expected to be in place, that you would expect would always be in place, and that staff would be aware of. Things that say until further notice or due to the outbreak we must do these things, suggest that those are temporary measures or you need to do something differently because of the outbreak when in fact, in many cases, those were standard things that you would expect to be in place in terms of making sure contaminated equipment is separated from clean equipment, certain doors are kept closed, those kinds of things.

MR. YOUNGER: Is it your understanding that those practices have now become permanent practices then or have the signs just disappeared and moved on?

MS. COLMAN-SADD: We haven't been back to do any audit work so I couldn't speak to that because we haven't audited it and I haven't toured the facility since then, so I don't know.

MR. YOUNGER: No, that's fair enough, I'll ask the other side here in a second. The last question I have, you didn't happen to get a copy or a picture of any of those signs or anything at the time?

MS. COLMAN-SADD: I would have to check our audit files, we may have.

MR. YOUNGER: That's fine.

MS. COLMAN-SADD: We had some photos of some things and I just can't recall, off the top of my head, what is in our files and what's not but we can certainly check.

MR. YOUNGER: Fair enough, thank you very much. Maybe that's a good place for me to start over here and I'm not sure if the deputy minister or the representative from the health authority would rather answer that, and I will try to give you a chance to address all the things. You've heard the Auditor General say that there was a defensive attitude that seems to have improved, I mean I want to recognize that, but can you explain why you think that happened, why would the nursing staff or the senior management have been defensive towards concerns around the infection control and why would they believe that you couldn't keep somebody in isolation?

MR. CHAIRMAN: Mr. McNamara.

MR. MCNAMARA: Perhaps I'll start, Mr. Younger, and then Ms. Calvert Simms may want to add to it. Just a couple of things, I think for staff and having been a CEO of a hospital, when an Auditor General arrives on-site, it's not something they're used to and going through a process with individuals who are questioning does create a situation for them, they have to think their way through, and I think as the leadership of the organization

changed its culture, that is why there is more openness. I think that happens. I can think of my own past, in working with staff, they are always concerned, when strangers show up, about what's going to happen to me, and that's normal.

I think the other part that I just would like to address a little bit, in some of your opening remarks, talking about things, well, why would we do a hand washing regulation? The reason we would do that is not so much that we know staff will report and work on that, but we want to get public confidence and one way to get public confidence is public reporting and that is the true reason for doing that.

MR. YOUNGER: Oh, I understand but my question was why it has taken - I mean we passed that bill and the minister said it was urgent in May, and here we are, we're into the next session of the Legislature and we still don't have regulations on something that's called urgent.

MR. MCNAMARA: I'll answer that. The reason for that is you have got to go and have a standard process. One of the problems that we have with reporting information across this country is, it is not standard. I can even go to wait-lists and say people waiting for surgery and so we'll have these measurements, but what happens is certain doctors measure from the time that a GP makes a referral, from the time that the surgeon then will have a short wait-list to surgery. The next doctor will do a lot of consults and have a long list for surgery but a short referral list. We report them the same and so it looks to the public like there is one consistent reporting system and it is not consistent, so the same applies.

What we want to do in this is make sure that the process and reporting that we put in place is consistent with every district, that we do the appropriate education and make sure that everybody understands the information we're looking for, so we report to the public that what happens in Yarmouth is the same as what happens in Cape Breton.

MR. YOUNGER: Okay, but if I am - and just to clarify, my point was that I think it could have been done without legislation, and fine, legislation was passed, and then I sit there and I say, well, it was the minister who stood up at a - I was at the press conference, and the minister said that this is urgent, it's critical, and this was one of the reasons. It troubles me that that urgency seemed to disappear once the bill was passed. I think this is different than some other things, so I guess the question comes, if you have a patient - and it doesn't really matter whether it's in Cape Breton or Halifax or Hants or wherever - with an infection like C. difficile, who is isolated, is it the policy and is it followed now that they will be isolated and not allowed to wander down the hall in a gown and a mask?

MR. MCNAMARA: I'll start. Again, the policy, and I'll go back to my own - we have a major issue with MRSA, which you referred to, in Bridgewater, and we recognized that we were at a high level. We put a team in place to address it.

One of the difficulties we had is what we call "wandering patients." I can't speak for the exact patient in Cape Breton, but you have some who have head injuries, you have some with - and they are very difficult to manage to keep in too. You can't tie them down - I mean, that's inappropriate as well, but it does create challenges for staff. As I say, I'm not speaking for Cape Breton, I'm just speaking in general. One of the things I do know from being a CEO is that it is difficult to prevent patients from wandering, to keep them in a certain area. Ones who are well aware of what is going on in their families, yes, you can manage. There are others who are a great difficulty. Dianne may want to add.

MR. YOUNGER: I understand it's difficult, but the job, it was just - what was it, last week or the week before, when the IWK said that people couldn't come to visit because they thought there was an infection or something. I think it was a week or two ago. I mean, people are used to that. I think people fundamentally understand that if there's a serious infection measures are taken.

Fine, I agree with you, that if you have a patient who decides they are going to run out of their room and down to the common room, there's not a lot you can do about that other than take them back to the room, but this kind of situation sounds like the hospital didn't think that was much of an issue because they had a mask and a gown on. I'm not even talking about this specific patient. What I'm trying to find out is, that seems to address the issue of whether the culture has changed and I'm just wondering whether that has been addressed, so that that's dealt with and not - you know, it is what it is, they have freedom of movement.

MS. CALVERT SIMMS: For this particular patient, when it was brought to our attention, we did immediately refer this to an ethics review, because could we actually keep a patient locked in a room if they chose to leave? I don't have the response in front of me, but I can make sure that you have a copy.

It does speak to a second issue, though, which is - and that is one of our learnings - we don't screen every patient who presents at our emergency department. We do ask them if they have diarrhea, but we don't test them automatically. They don't always tell us if they have diarrhea and we don't test every patient for C. difficile. So from a broader sense, we need to change the total culture so that we do make sure that hand hygiene is a priority, whether patients are on infection prevention and control practices or not, because we don't know who comes in through the door. We don't know whether they have MRSA, VRE, or C. difficile.

MR. YOUNGER: Well, let's talk about that, because in January of this year there was another outbreak that was reported. One of the things the health authority spokespeople said at the time - and maybe they spoke out of turn and shouldn't have said this - but they said it was a breakdown in our system. The phrase they used was "breaks in precaution." After going through two outbreaks in 2011 and an audit, what happened that - and I acknowledged before that infections and disease happen in hospitals, but what

happens that causes, just months again later, another breakdown in - and the word they used, "precaution" - in the system that would allow that to happen again?

MS. CALVERT SIMMS: Are you referring to the outbreak . . .

MR. CHAIRMAN: Order, please. Mr. Younger's time has expired. Mr. Orrell.

MR. EDDIE ORRELL: Thank you for your presentations here this morning. Being a former health care worker, I listened to the responses and the questions and the presentations. I'm quite interested in the responses coming back. What I did hear, though, is a questionable staffing issue in some of the departments that are responsible for cleaning and SPD, the cleaning of scopes and so on and so forth. I hear that some of the evidence showed that there was no cleansing of some of the scopes and that there was a lack of evidence provided that that cleansing was done.

Would you say that this was because of the lack of cleaning or could it have been just the lack of reporting because of cutbacks and how busy some of the busy operating rooms are and the need to have that equipment back would just not have been reported, or would it be just that there was evidence it wasn't clean? How would you test to say that it wasn't clean?

MS. COLMAN-SADD: I think, at the end of the day, it is very difficult, in some instances, to say exactly what the issue was. I know when we searched for evidence that the scopes that we selected - so we selected particular days and we tested - when we searched for evidence of cleaning and disinfecting, it wasn't there. At some point, eventually, staff at Cape Breton were able to find evidence that a significant number of those scopes had, in fact, been cleaned and disinfected. I believe there were two, at the end of the day, in Cape Breton for which no evidence was able to be found.

I think the issue, though, lies in the fact that when your documentation isn't there and when there isn't some evidence that staff are regularly checking various things to make sure that the disinfecting did occur, the cleaning occurred first and machines completed cycles and all of those kinds of things, that the overriding concern then becomes - would staff notice when something didn't take place that should? Would they recognize that perhaps that scope shouldn't go back into use and maybe needed to go back to the beginning of the process again?

At the end of the day, for some of the scopes - initially there was a very large number for which we couldn't find evidence. Ultimately, they were able to find some evidence for the majority of those that satisfied our audit procedures, but, again, staff there had to spend a tremendous amount of time looking for that evidence and finding it, so I question how well they would have been aware at the time and positive that those scopes had been cleaned and disinfected.

MR. ORRELL: So it was a lack of reporting rather than, basically, a lack of actual work being done?

MR. LAPOINTE: I'd say it is more than that. When we look in an audit test to see whether some activity has occurred, like was a scope cleaned or was it not cleaned, if we don't find evidence that it was, we don't make the assumption that it is just because it happened but there was no paperwork. What we conclude is that there is no evidence it was ever done and no one can prove to us that it was done. If I start from the assumption that we don't know if it actually was, in this case, cleaned, unless we find there's something to indicate that it was, it might even be anecdotal that someone says, well I didn't write it down, but I was there and I remember doing it - we found nothing to indicate.

The other issue with that, of course, is that if we couldn't tell whether it was cleaned or not, the staff who were using this equipment would have no way of knowing whether it was clean or dirty. There was nothing to say, this one is clean and this one is dirty; use this one, don't use that. They had no idea and could not tell us. So while it's not a definitive thing, it rarely is that we can say there was evidence it was not done, there's nothing to say that it was and no one, at the time, in the area, knew whether it was or not either.

MR. ORRELL: In the follow-up action in the report, we're talking about containing more technical elements, environmental cleaning and hygiene. Has the staffing been improved for that to happen within the district?

MS. CALVERT SIMMS: Yes, the staffing has been improved. We've added the equivalent of 3.5 FTEs to the Infection Prevention and Control department and a dedicated manager.

MR. ORRELL: That comes with a price, obviously. Did that funding come out of the existing hospital budget or did the Department of Health and Wellness give you additional funding to see that that took place?

MR. JIM MERKLEY: Both. We initially paid for the additional cost for the C. difficile, the increases to the staff and other expenses, and that has been reimbursed by the department to us.

MR. ORRELL: You moved to a real-time electronic hand hygiene auditing system. Can you explain that to me and how that works?

MS. CALVERT SIMMS: I think it would be easier to show you. It is an electronic reporting system so that when the staff are on the units and they audit the four moments of hand hygiene, there are a certain number of interventions that they have to measure and a certain number of observations that they have to make. It was one of the earlier criticisms that maybe our audit size was too small, so that has been expanded. They can show the staff

immediately once they've finished their round of audits exactly what their hand hygiene rate is.

For example, one recent audit, the hand hygiene rates were well over 70 per cent on one particular unit but we had an issue with one group of staff, one professional group of staff. We're able to address that immediately, so they see the results real-time in a graph. We can give them those results and those are posted on the units.

MR. ORRELL: How are you monitoring the percentage of the hand washing? Is there someone there watching?

MS. CALVERT SIMMS: Yes, you have to observe the four moments of hand hygiene: pre-patient contact; pre - if you're doing an aseptic technique; post-waste disposal; and post-patient contact.

MR. ORRELL: We talked about changing our cleaning products and practices. I know back 10 years ago they changed the cleaning product from a Javex-based product to something different that didn't really have any cleansing agent in it because of sensitivities of staff and visitors and patients alike. You're talking about changing back, is that going to affect - what are you going to change to that will be different or would it be back to what we started with? That seemed to work at the time but because of sensitivities it wasn't deemed acceptable. If you're going to change to something different, what will happen with potential sensitivities of staff, patients and/or visitors?

MR. MCNAMARA: Perhaps I'll ask Suzanne Rhodenizer-Rose to answer that.

MS. SUZANNE RHODENIZER-ROSE: There are a lot of different products on the markets now for dealing with C. difficile. Usually we recommend that a facility use a sporicidal product so it kills the actual spores that C. difficile generates, as it's easy to kill the bacteria but it's very difficult to kill the spore. That's why you usually need to bring in a newer, stronger product when you do have C. difficile cases on the units.

There are lots of products on the market now, whereas probably 10 years ago we only had Javex and there are some problems with Javex being used: it's difficult to dilute; there are occupational health and safety concerns with the off-gassing of it; and you also have to do a pre-clean before you apply the Javex, which isn't often done in facilities so you're leaving out a step, so essentially you're not doing the cleaning before the disinfection. Some of the newer products that are on the market take care of that in a one-step process.

MR. ORRELL: We also talked about understanding what the barriers are to preventing and cleaning up an outbreak. Are there any real identified barriers that we could look at maybe preventing the next time around? I know the changing of the furniture, but is

that feasible for every area of the hospital that may have a chance of, say, a C. difficile outbreak?

MS. RHODENIZER-ROSE: In preventing outbreaks you need to have consistent practices applied pretty much all the time. Some of the basic things that at infection control we education staff on are routine practices: you always wash your hands, you always clean off your equipment before it is used on another patient, you isolate accordingly, and you use personal protective gear. These are all very rudimentary basic practices that we expect health care providers to implement any time they are dealing with a patient. When those practices fail, due to whatever reason, it is then that you run into problems with transmission of infection.

It's education, it's reinforcing, it's auditing and doing that direct observation and giving real-time feedback to staff so that it becomes part of their routine, every day. It's a fact of life, actually, in health care facilities that there are breaks and nobody is 100 per cent perfect all the time, but through education and continuing to support staff and giving them the resources that they need to do the job well, that compliance with practices improves, and hopefully prevents, outbreaks from happening in the future.

MR. MCNAMARA: I would just like to add to that. It's interesting a number of years ago there was a program tried province-wide about washing hands called *It's OK to Ask,* to ask patients and people to ask their health care provider to wash their hands before they touch them. It was interesting, patients were afraid to do that and what was also interesting, in culture, is even other health care providers, even doctors, would not ask another doctor that question. I don't know why that's there but this is something you have to keep reinforcing with individuals that it is okay to ask.

It's an interesting conundrum that individuals who are going to be looked after, even by professionals, will not ask another professional that question. I think we have to keep reinforcing that culture that it is okay to ask, at every time, have you washed your hands before you provide care to me? As a physiotherapist I'm sure that you would recognize that many people did not ask you that question.

MR. ORRELL: Oh they did.

MR. MCNAMARA: Some did but not all.

MR. ORRELL: They did, but we also had adequate training through the district health authority. They were constantly training all staff in infection control practices, hand washing, and it seemed like a lot of times people would say, okay we've done that, but the more it was reinforced the more it would happen. That's just one of the things that has to be done, I understand that, but you've got common areas in, I'll say, an emergency room that wouldn't be cleaned after each person got up out of a waiting area chair, that would be an enormous amount of work for a cleaning staff and/or budgetary restraints. That's some of

the stuff that - although I can wash my hands, and if I'm working in an emergency room and someone comes in from the waiting area that sat in a chair that had, well that person is going to pass it on to whoever, wherever. So how do we prevent that?

MR. MCNAMARA: It's always difficult to do that but we try to keep it to - I guess, particularly when know we have an outbreak of some type - to try to do the appropriate cleaning. It's something we have to keep pushing and keep asking people to do and it is important that staff take the time to do that because we can talk about cost but the cost of not doing it is more expensive than the cost of doing it. We try to talk to organizations about that and to recognize that if you can prevent an outbreak it is much cheaper than trying to deal with the individuals who are impacted by an infection outbreak.

MR. ORRELL: There is a recommendation in the audit that the province should initiate a province-wide surveillance system. Has that been done?

MS. RHODENIZER-ROSE: We're in the process right now of developing some key infection control indicators, the first one would be hand-hygiene compliance adherence rates, and also public and departmental reporting for Clostridium difficile. Once we have those in place and districts are starting to do that reporting to us and to the public, we'll be rolling out other key infection control indicators. We've worked very closely with the Canadian Patient Safety Institute to utilize their database so that we actually have an electronic means to do trending and look at the data, provincially, so that we have a capacity to benchmark as well. That is in the process of being implemented. We expect that the first reporting will occur April 1, 2013.

MR. ORRELL: Okay, I thought I heard earlier that that was due to be on by December of this year.

MS. RHODENIZER-ROSE: The protocol for the auditing practice will be ready by December. Districts will start collecting data for January, February, and March, and that data for that quarter will start being reported publicly and to the department as of April 1st.

MR. ORRELL: And that's still on track for that, then.

MS. RHODENIZER-ROSE: Yes.

MR. ORRELL: We all know the budgetary problems are concerned - health care budgets have taken some drastic cuts over the last couple of years, as have education and so on. Have budget cuts to the health care system had any effect on the implementation of this and protecting Nova Scotians from infections such as C. difficile?

MR. MCNAMARA: In terms of budget, yes, there have been cuts in budget, but we have directed district health authorities to not cut budgets that impact patients. As has been mentioned, we have added some money to Cape Breton District Health Authority, as well

as looking at how we change budgeting issues within our own department to support infection prevention. It comes down to choices, and it is frequently saying, is infection prevention a life-and-death issue? At times it is, but there are also drugs that we have to look at. There are life-and-death issues there, other procedures, and it's a constant issue that we struggle with - what becomes my number one priority that I fund?

It changes sometimes, depending on the issues that we're facing. When we were faced with the issue in Cape Breton, that was raised as a concern within the department and within government, and we did make some changes to provide some funds to assist with that. We are looking at some other opportunities to increase our staffing into the future in our department to help the district health authorities.

We also have to look behind district health authorities. We have to look at the long-term care sector. We have to look at the home care sector. We have to look at others, and those also have issues that we have to address and make sure that we have a safe health care community through the whole continuum of care.

MR. ORRELL: Are the communication-reporting avenues between the department and the ground-level staff enough to ensure that Nova Scotians are getting safe and effective care?

MS. RHODENIZER-ROSE: We work regularly with the infection control practitioners in all the district health authorities and the IWK. We've had close contact with the practitioners in Cape Breton, so the information that we receive related to best practices or innovative ideas for infection prevention and control, we share those across the board with our colleagues in the districts, in the hopes and the expectation that's shared with front-line health care providers.

MR. ORRELL: How are we communicating that with all the residents and patients in Nova Scotia? Is that getting out, that that is being done? Do they know that? Do we understand - does the everyday user of the health care system know that it's being done? Is that being communicated effectively?

MS. RHODENIZER-ROSE: To be honest, I don't know if the front-end user knows that, or the patient. It's our hope and our expectation - we are very open and transparent with the information that we have. We have regular dialogue. We encourage the districts to share this information within their organization and with their patient population, but to be honest, we don't have any way to really assess whether the patient is aware of that or not.

MR. ORRELL: Is there some way we can probably open that communication line up, with signage or Web sites or something like that, for the general population to get that message out? I think it's important. If we get that message out to the people who are using the system, then they may be more diligent in - maybe when they enter the facility, to be

washing their hands, or when they leave the facility, wash their hands. I know you watch people come and go in the hospital and the hand-washing system is at the door, but a lot of people walk right by it, in and out. If we could communicate that more effectively to the staff - and could we look at signage? Could we look at Web sites?

MS. RHODENIZER-ROSE: In looking at and being in some of the districts and the IWK, I am quite confident that the programs that are in place there are doing a lot of public education. They do have a lot of signage up. Sometimes you have to change the signage, because it gets to be old hat after a while.

Part of what we're doing at IPCNS is to engage the public and inform the public, and part of the Patient Safety Act is to have that public reporting, so there is transparency and the public will know what the rates are for various organizations. Most people in the public are lay folks, so part of that reporting will involve putting those numbers into context so that they are easily . . .

MR. CHAIRMAN: Order, please. Unfortunately, Mr. Orrell's time has expired. Mr. Ramey.

MR. GARY RAMEY: Mr. Chairman, I'll be sharing part of my time with my colleague, the member for Hammonds Plains-Upper Sackville, and I'll be focusing my questions - we've had two briefings from the Auditor General on matters related to this so I'm actually going to focus my questions to the witnesses who were good enough to come here this morning and I appreciate that.

My first actually two questions are pretty much yes/no ones. So I'll state it and I'll just get a yes or no from somebody over there. It's my understanding that there were 20 recommendations by the Auditor General and all of those 20 were accepted. We've had 14 completed; two of the six that were scheduled to be completed by the end of September continue as a work in progress; four recommendations require more time and evidence to be completed; with the completion goal, for all six recommendations remaining, of December 31, 2012 - yes or no, whoever wants to answer over there.

MS. CALVERT SIMMS: Yes.

MR. MCNAMARA: You've got three yeses.

MS. CALVERT SIMMS: It's called teamwork.

MR. RAMEY: Thank you very much for that. I'd like to focus on Recommendation 4, in the progress report of October 24, 2012, by the Auditor General. CBDHA has hired and oriented four new infection control practitioners and all four are currently enrolled in the two-week Scarborough Centennial College Infection Prevention and Control course, with a completion date of November 2, 2012. The IPAC team makes regularly scheduled

visits to their assigned areas of responsibility. Status: This recommendation is complete. Is that correct or incorrect?

MS. CALVERT SIMMS: That is correct.

MR. RAMEY: Thank you, okay. Now, in relation to that - this won't be a yes or no question - can you explain where the additional staff have been assigned that were hired in Infection Prevention and Control in your district?

MS. CALVERT SIMMS: I don't have the assignment list in front of me but I can tell you that staff cover all our community hospitals as well as the regional referral centre. So that would include Baddeck, Neil's Harbour, Inverness, Cheticamp, Northside General, New Waterford, Glace Bay and Cape Breton Regional.

MR. RAMEY: So they're assigned throughout the district?

MS. CALVERT SIMMS: Yes.

MR. RAMEY: And just for clarification, I mean I know what the term describes, infection control, I'm kind of aware what that probably entails but what specifically are their responsibilities? Can you tell me a little more about what they actually do or how they do it?

MS. RHODENIZER-ROSE: Infection control practitioners have - let me back that up a little bit. There's a national association, it's called CHICA-Canada, and there are professional and practice guidelines that infection control practitioners use to guide their day-to-day activities. Some of the biggest items on their to-do list would be surveillance of health care associated infections. So about 60 per cent of the role is related to conducting surveillance activities, doing that trending, and then evaluating the results.

The other piece of their day is to educate staff, patients, and families; to conduct audits - not just of hand hygiene but audits for cleaning; adherence to use of personal protective equipment; and isolation practices. So their day is fairly busy with surveillance, education, and auditing; those are three big-ticket items for ICPs.

MR. RAMEY: Now, how long have they actually been doing this? Has it been since November 2nd or has it been earlier than that - the infection control people who are on site. When did they start their actual duties?

MS. CALVERT SIMMS: The staff that we already had were doing that. The new staff have actually been coming in over a period of time since the Fall - early Fall - so they had started some of their work, but they're on the ground now full time.

MR. RAMEY: In relation to the four recommendations that are sort of ongoing from the Auditor General's Report, four recommendations require more time and evidence to be completed, with the completion goal of December 31st - I'm just referring specifically to those now. What types of challenges do you have, or are you having, in implementing those, would somebody like to comment on that?

MS. CALVERT SIMMS: The recommendations that we continue to work on are around education, also certification of our infection prevention and control practitioners; that is a five-year process to secure the certification. Other areas are around the first outbreak report. We've put a lot of our time and energy into making sure that we've addressed the recommendations that are going to make a difference to patients and that is where our primary focus has been. For the first outbreak report we did have two external reviews that were done, independent of the Auditor General, Public Health Agency of Canada as well as my Infection Prevention and Control Nova Scotia colleagues. So we did have those reports that we're also working on.

We're pretty close to being done with the first outbreak report but we did want to go back and make sure that we had verified our case numbers and that's what we were doing because we were counting beyond the outbreak time. We don't anticipate that that will be a problem in having that report completed before the end of the year.

As with all of our communications, we do make sure we provide regular updates to the public and transparency in terms of our communications and what we can share because that is really important for us. We can't re-instill public confidence if we're not transparent and if we're not open and if we're not honest and if we don't share what the difficulties are, the challenges are, in meeting the objectives. I think that is where most of our work is ongoing.

MR. RAMEY: Okay. I do have a question related to the funding that has been put in place to do some of these things but I think I'll leave that for one of my colleagues. My final question, though, is a more global question, a bigger question. It relates to health care not only in our province but in Canada because I do know when I'm listening to the news I often hear about C. difficile outbreaks in New Brunswick or in hospitals in Ontario. Can somebody tell me just how big a problem this is, you know pan-Canadian, across Canada? Are there any statistics on this or would anybody like to comment on that?

MS. CALVERT SIMMS: It's interesting, I don't have the statistics but it is a pan-Canadian problem and I recently, in fact just this past week, myself and a colleague had the opportunity to present at the Canadian Patient Safety Institute Conference on lessons learned for C. difficile and managing C. difficile outbreaks. That provides us with an opportunity not only to share our learnings but also to learn from others. The conference was for five days, a number of presentations were made.

Certainly, one of the learnings that we've taken away - many learnings but one that really spoke to us - was how do you restore public confidence and how do you measure that? Certainly the work that has been going on in Niagara Health Region, they have actually created their board's score card, which is a report on measures that they use to determine public awareness, public confidence in the organization and what the organization has accomplished and that is certainly something that we'll be looking at, going forward.

When you ask, again, is this a bigger issue? It certainly is a national issue and in discussions with the CEO at the Canadian Patient Safety Institute, he was certainly interested in exploring a better network, pan-Canadian, so that we are able to support our colleagues when this happens elsewhere in the country, such as recently in New Brunswick.

MR. RAMEY: I know if I start another question I will probably get knocked off in the middle of it so I'm going to turn the question over to my colleague, with the chairman's permission, my colleague from Hammonds Plains-Upper Sackville.

MR. CHAIRMAN: Mr. Whynott.

MR. MAT WHYNOTT: Thank you for coming in today, good to see you again, Mr. McNamara and Ms. Calvert Simms as well, and everyone else. I do have a few questions, one in particular for Mr. McNamara, around past Auditor General Reports and the question of the compliance with those recommendations. My understanding is that the Department of Health and Wellness is the leading department in Nova Scotia as far as complying with the recommendations and implementing those recommendations. Am I correct in saying that?

MR. MCNAMARA: Two years ago, we were looking at the Auditor General's - we probably were the worst. I made a commitment to the Auditor General and to working with our staff to go from worst to best. We're not there yet, but we're moving in that direction. We have done a tremendous amount of work to catch up.

In trying to do this we have to go back a number of years and back to previous governments, to reports, to catch up. At the same time we're getting new reports from the Auditor General, so we're trying to do the past and the present at the same time, but we will get to best. That's our commitment.

MR. WHYNOTT: Yes, I think that's an important thing, because obviously the Auditor General's Office is an important piece of the way we as a government - no matter who's in - are accountable to the residents of Nova Scotia.

One thing I know, it may not necessarily be - I don't think it is the same sort of outbreak, I suppose - but with regard to what we saw around H1N1 and that whole public

awareness around the importance of washing your hands and those sorts of things. Have we seen a change with regard to how the public treats this? Obviously there is still more work to be done, but have we seen that? I know there's not necessarily data to show that, but I guess - I certainly see it all the time with people using the hand sanitizers and washing their hands more frequently. Are we seeing that?

MR. MCNAMARA: My response would be that I think in the health care system, we're doing a better job in around - and we're seeing more of it. I would say in the general public, I have to be honest, when I go into washrooms and observe the number of people who still leave without washing their hands, we have a heck of a lot of work to do in the public to get people to understand that washing their hands is important everywhere.

MR. WHYNOTT: Ms. Calvert Simms, I have a question with regard to Accreditation Canada. Can you explain what this organization does and who they are?

MS. CALVERT SIMMS: Very simply, Accreditation Canada is an arm's-length organization - private, not for profit - that has established evidence-based standards against which health care systems can be evaluated. The process for doing that is they have trained surveyors - they will assign a team of people to an organization, and using those predetermined standards and well-established, research-based processes, will evaluate organizations' compliance with those standards.

MR. WHYNOTT: So are those teams - the groups of people that come to, for instance, the Cape Breton District Health Authority - health care professionals? Or what sort of people are they?

MS. CALVERT SIMMS: They are actively working in health care organizations across Canada.

MR. WHYNOTT: I see.

MS. CALVERT SIMMS: I'm also an accreditation surveyor.

MR. WHYNOTT: I understand there was a - more recently, as you mentioned in your opening statement, as of June 1st of this year, Cape Breton District Health Authority became accredited under this organization. My question to Mr. McNamara is, are there other district health authorities in Nova Scotia that are accredited by Accreditation Canada?

MR. MCNAMARA: As a matter of fact, all of our district health authorities were accredited. The amazing thing this year is that a high majority of them received accreditation with exemplary status, which is the highest accreditation you can get. We're really pleased that Nova Scotia has been so recognized. As a matter of fact, percentage-wise, we'd be the highest in the country.

MR. WHYNOTT: I know the executive summary around - I did want to read that just for the record, because I think it's something to hang your hat on. The organization is commended on its response and the implementation on ongoing efforts related to the C. difficile outbreak. Of note across the organization are the number of strategies that were in place, which has enhanced awareness to hand hygiene. These include: the number and locations of dispensers in the facilities; the installation of additional sinks; the enhanced education of housekeeping staff; the environmental services auditing; the ongoing monitoring and surveillance; and overall, the exceptional cleanliness of all the facilities that were visited. It goes on but I'm not going to read on there.

I did want to ask a question to – oh yes, of course, also in that, it talked about the amount of hand-washing stations, so Mr. McNamara, in addition the department gave, as you mentioned in your opening comments, $2 million to the health authority, can you explain the importance of that and why that happened?

MR. MCNAMARA: The reason that this came about is that in working with the district and working through the reports received from our own staff, the issues that had to be addressed, for example, additional sinks in the area, identifying that there was some replacement and repair of four areas where there was a crack. Also, when you have issues where there is breakdown in maintenance, that is a perfect place for spores to lie, so we wanted to make sure that those were fixed and repaired. In working with the district we identified those issues and provided the money so that they could bring it up to a standard to be able to prevent this in the future.

MR. WHYNOTT: I know that under Minister MacDonald the department set up a patient safety committee in 2010, can you talk about what that committee does? My understanding is also it's the first and only of its kind to help prevent and provide central oversight for patient safety.

MR. MCNAMARA: It's the first and only of its kind in Nova Scotia. There are a number of other institutions in other provinces, of quality council. We went to an advisory committee rather than a council, again trying to work within the resources we have within the department and within the district health authorities, to make this work. It is currently chaired by Dr. Peter Vaughan, who is the CEO of South Shore Health, but is also the recently past-president of Accreditation Canada, and brings a lot of expertise in this area. It has individuals from various district health authorities, from legal to risk management, who bring different types of expertise to the committee. What they do is provide advice to the minister, to myself and also to Suzanne and others, on practices that we can put in place.

We are looking at a whole variety of issues of how we can improve patient safety, whether it is from surgery to infection control to various areas – but it is a start. We have a lot of work to do. We will continue to do it to ensure that we provide safe patient care to Nova Scotians.

MR. WHYNOTT: Earlier I was looking for my question. I found it as I jotted it down. I just wanted to go back to, in particular, the district health authority. Mr. McNamara, you mentioned in your opening comments around an unannounced site visit. Why was that done?

MR. MCNAMARA: The reason that I asked Suzanne and her staff to do that was to give public confidence to what was taking place in Cape Breton. Normally in most audits people know you're going to show up and we thought that because of what occurred at the Cape Breton District Health Authority, we felt it was important to do an unannounced visit so that we could have public confidence in what had improved in that district.

MR. WHYNOTT: There was also something mentioned, I believe, with the health authority that you actually update on a regular basis the recommendations from the Auditor General. I assume it's on your Web site.

MR. CHAIRMAN: Ms. Simms.

MS. CALVERT SIMMS: Yes, it is on our Web site and we recently did a media release in which we shared the progress and the recommendations.

MR. WHYNOTT: And does that get picked up by the media?

MS. CALVERT SIMMS: Absolutely, we had a huddle.

MR. WHYNOTT: Okay, good. And is it posted in the hospital at any point?

MS. CALVERT SIMMS: It is on our Intranet, as well as on our Internet.

MR. WHYNOTT: Okay, thank you very much. Mr. Chairman, what is my time?

MR. CHAIRMAN: You have eight seconds left.

MR. WHYNOTT: Thank you very much, Mr. Chairman, I'll finish there. I'm sure my other colleagues will have questions, thank you.

MR. CHAIRMAN: Thank you, Mr. Whynott. Mr. Younger, you have 12 minutes.

MR. YOUNGER: Twelve minutes, thank you. I appreciate my colleague giving me his six seconds. I wanted to follow up just where we kind of got cut off and left off, and I can table the article. This was the "breaks in precaution" issue. So you had one breakdown with C. difficile. Obviously, it was important to address that. The auditors had been there by this point, and then what appears to have happened, at least according to the reports at the time, was that there was improper disposal of bedpans and commodes and they weren't being emptied in appropriate areas. The reason given, at least to CBC at the time, was that

it was a breakdown in the precautions. So the question that I was asking there was - and then we ran out of time - I don't understand how just months after a major C. difficile outbreak you could have another one that even the health authority seemed to admit was a result of a breakdown in procedures.

MS. CALVERT SIMMS: First of all, I'll come back to the second outbreak. It's important to note the difference in the number of cases. There were six in the second outbreak, and we erred on the side of caution in calling it an outbreak. The reason for that was because, having been through a major outbreak with a significant number of cases, we wanted to make sure that we were right on top of this one, that we were responsive. We were coming into Christmas. We did not want to leave staff feeling unsupported, a number of staff being away, so we wanted to make sure that we had the mechanisms in place to maintain ongoing daily support, which we did. We conferenced daily right through until the new year. Even when people were away and in other parts of the country, they were expected to be on the calls so that they could follow up with their team members.

With respect to those numbers, three of the cases were in our intermediate ICU, and what we uncovered once typing had been completed was that those three were three independent strains, and therefore could not have been - it was not due to transmission. The three cases that we did have on one particular unit, which we also declared the outbreak on, we did trace back to one room, which could be contributed to whether that was cleaning practices or whether that was waste disposal.

One of the biggest challenges we have had is putting in an effective waste disposal program. It means leaving the patients' rooms with covered bedpans because we've removed one. It means getting down a hall and effectively disposing of the waste. There are times - and I've said that energy has to be put to making sure, what are the barriers to staff being able to effectively use the right infection prevention and control measures? Is the barrier that they have too far to go to dispose of the bedpan? Is it an alternative that can be put into place?

There's no one standard policy when it comes to waste disposal, because the units are designed differently, the hospitals are designed differently. We have different patient populations in those areas and the locations of the soiled utility rooms are in different places. So it's why in my report I speak to that vigilance is ongoing and we have to make sure that we pay attention. We certainly welcomed the opportunity for unannounced visits, and we continue to welcome that, because that helps us stay vigilant and helps us bring up the opportunities to staff where we see that things haven't been adhered to.

MR. YOUNGER: I guess what troubles me is just that so quickly there appeared to be this breakdown in the procedures, even if it was a smaller outbreak, or even if you don't want to call it an outbreak. There has been the internal report released on the second outbreak, but my understanding is that an internal report on the first outbreak - which has

sort of been promised at different dates, most recently by the end of October - still has not been released. Can you provide an update as to when that might be expected?

MS. CALVERT SIMMS: As I indicated in an earlier response, much of our effort - from the first outbreak we had two independent external reports. One was from the Public Health Agency of Canada, which helped provide us with the demographics of the outbreak - so the type of patients, what antibiotics they were on, whether there was any indication that there were certain rooms that contributed to a patient contracting C. difficile, and really trying to understand that component of it and then work on the recommendations from that, and then the recommendations from the interim report that we had from Infection Prevention and Control, so we were also working on that.

Part of our challenge has been with the second outbreak. Between the second outbreak and the first outbreak we have changed case definitions based on the latest evidence, so what constitutes a case for a C. difficile patient: what we wanted to make sure that we could do was compare apples to apples, so we've actually gone back and reviewed every single case from the first outbreak, making sure that the definition applies. We will have that report before the end of the year.

The second piece to this question that I think needs to be noted is that because we are trying to address the recommendations and we do have finite resources, we had to prioritize what was most important. What we felt was most important was to try and address the recommendations because we did have the two external reports.

MR. YOUNGER: One of the recommendations I would like to ask you about is, I understand you were the vice president for patient services and chief nursing officer before this position. One of my colleagues talked about the disinfection procedures and my understanding is that at the time, you disagreed with the Auditor General on whether cleaning and bleach was necessary or whether just bleach was necessary. I'm wondering what your feeling is on that issue now, whether both are required or just bleach.

MS. CALVERT SIMMS: I believe the actual - and not a disagreement - I would prefer to think that we were having a discussion as to what was the best measure. Part of the challenge that we had was not the cleaning product we were using, but the process. It requires a 10-minute dry time and that's one of the reasons our colleagues from Infection Prevention and Control recommended Rescue.

The challenge with Rescue is that it is extremely toxic. You have to be very careful with it. Staff need a lot of education on how to use it and some of the side effects we saw through Occupational Health and Safety were of concern to us. Also extended use on our medical equipment, it damages your medical equipment. Anything that has a glass face, it turns it opaque over a period of time. Anything that is - I don't want to say stainless steel - anything that has a shine on it, it actually removes the shine.

It is quite a toxic product, so we'd like to make sure that whatever we're using is not only safe, but does the job. That's more around - so what is the evidence telling us? What are they using elsewhere now in Canada? Any of those discussions and anything that we do in terms of looking at those products will be done obviously in consultation with Infection Prevention and Control.

MR. YOUNGER: So what are you doing now?

MS. CALVERT SIMMS: We're still using Rescue.

MR. YOUNGER: You had talked a bit earlier about six FTEs who have been hired to deal with the infection control issues and I'm just wondering whether those are solely dedicated to the issue of infection control or whether those FTEs also have other responsibilities.

MS. CALVERT SIMMS: We added 3.5. We actually have 6.5 in total and they are dedicated to Infection Prevention and Control across the district.

MR. YOUNGER: So they don't have other responsibilities outside of that.

MS. CALVERT SIMMS: No. We have added a manager who will have no other responsibilities. We have an interim manager in place right now.

MR. YOUNGER: I think a lot of people are going to wonder, coming out of this, especially given the seriousness and the potential seriousness of these infections, I know you've said that you're in the process of implementing many of the recommendations, some of them have been implemented, when can people expect to have the full slate of recommendations implemented?

MS. CALVERT SIMMS: I think, as I indicated in my presentation, the full slate of recommendations will be implemented by the end of December, but it doesn't stop there. It will be ongoing. What we've used as a term of, "have we met the recommendation?" is that there is substantial progress. If we don't believe that there is substantial progress or sustainable ongoing process, then it will not be determined as complete.

MR. YOUNGER: I agree that it would be ongoing, and I suspect that the procedures will change over time as best evidence comes out. How would it be different if there is another outbreak? I recognize that infections happen in hospitals, but it's all about the culture and how things are handled. So if there's an outbreak in two months, how will it be different?

MS. CALVERT SIMMS: I think if you look at our December outbreak, and also this summer we saw a slight increase in our numbers, it's our responsiveness and our cautiousness, we will now always err on the side of caution. If we see that numbers are

starting to increase, we don't wait to declare an outbreak, we do ramp-up procedures, we make sure - we talked about interim signage before. Interim signage is important because it flags - it doesn't take away that it should be a basic part of everybody's practice but what it does do is it does flag that we're in a situation, especially for the public, that we need to be more vigilant. So when they see signs go up - we do our media releases, we give them warning, we limit our visitors - they know that we're serious.

MR. YOUNGER: The problem is though when the signs come down, then that can cause people to suddenly be less concerned, which is exactly why the Labour Department goes out and makes sure that people have hand-washing signs up in restaurants - it's because it's always important and it's meant to be a constant reminder.

MS. CALVERT SIMMS: Our hand-hygiene signs are up constantly; it's just specific notices that would go up.

MR. YOUNGER: I know, but I think we were talking about issues that need to be addressed all the time, like infection control issues and so forth.

I think that's probably the end of my time.

MR. CHAIRMAN: Yes, thank you, Mr. Younger. Mr. d'Entremont.

HON. CHRISTOPHER D'ENTREMONT: It's a pleasure to see you all here again today. Again, to the Cape Breton District Health Authority, it's a shame it happened to you but it was sort of one of those issues that C. difficile has gone its way through Canada - different infections, different hospitals - that eventually it was going to end up showing up here at some point. My thoughts were with the families and, of course, with the health authority as they were going through that difficult time.

During my time as minister, I had the opportunity to be at a number of conferences that talked about infection control, and more specifically had some good discussions with Quebec at the time. I remember Quebec had a number of outbreaks in a number of different hospitals as it was trying to sort of grab hold of this. At that time what the government ended up doing really is posting everything on-line, making it a complete public show so that hospitals and districts could measure themselves against each other and come up with the best avenue or ways to fix it.

My question more for the department at this time is how we are going to address the nine district health authorities in making sure that - I mean in your opening remarks and in your opening comments, it was making sure we had policies and procedures and reporting functions that were similar so that we're able to grab hold of it. So I'm just wondering, where are you with that? I think that's going to be an important part of this whole process to make sure it doesn't happen everywhere.

MR. MCNAMARA: Thank you very much for that question. Where we are, as was mentioned by Suzanne and myself in our opening remarks, we are developing consistent standards and reporting relationships across the province. It's of interest, I was talking to Janet Knox earlier this morning on another issue and I mentioned I was coming here to discuss this issue, and she said one of the important things that happened in Cape Breton is that we've all learned from it. She said the collaboration and co-operation that is taking place among districts now, being able to take lessons learned from what happened in Cape Breton that we're using now in Annapolis Valley, to make sure that what happened there does not happen here, there's the early learning signs that it came about.

So it's not only what we're doing within the department, it's what the district health authorities are also doing in working together to make sure that we work in a common way, to have a common interest, looking again to reduce the possibilities, and we will continue with that due diligence into the future.

MR. D'ENTREMONT: Is there a larger role for Infection Prevention and Control Nova Scotia to wield the big stick - that's probably the wrong thing - to provide that central way to say, listen, you're doing it wrong, you'd better get it fixed now or we're into some bigger problems? Is there a bigger stick that we can provide them in order to make this happen?

MR. MCNAMARA: It was mentioned, I think, in the Auditor General's Report that maybe Infection Prevention and Control did not have the authority to make things happen. As you would realize as a former minister, the minister does have the power to mandate and make things happen, and that's something that we do use when it is necessary. So there's no problem with having that authority, to having the stick, but what I found is that when it is brought to the attention of district health authorities, the standards they have to deal with, the issues that can be caused, that they step up to the plate and start to work together to make sure that stick is not necessary. But if the stick is ever necessary, it is there and it's something we would not hesitate to use if necessary.

In working with the district health authorities, as you know during your time - and it has continued since - the CEOs meet on a monthly basis with myself, the various VPs of medicine or clinical people also meet monthly and go through it, and then Suzanne is working with the various infection control people across the province so that we do work together, we learn from one another, and do a better job of making sure that what happens in one area doesn't happen in another.

MR. D'ENTREMONT: In the research that you're doing, have we looked at other jurisdictions - I mean I'm just coming back because that's the one I remember the best, but are there different models or are we adopting a model from somewhere or are we just trying to make it up as we go?

MS. RHODENIZER-ROSE: What we do in Infection Prevention and Control is we look at some of the lessons learned; so not just from Cape Breton, but other outbreaks that have happened in Canada and across the world and our best practice guidelines that are developed nationally and through experts in the field inform our work. So a lot of times with IPCNS we'll look to other guidelines and standards and adopt those for practices in Nova Scotia. A key one would be C. difficile. Although we're in the process of developing provincial guidelines for C. difficile for use in Nova Scotia facilities, we're also adding a policy to that guideline that says thou shall adopt these guidelines within all the district health authorities and the IWK.

MR. D'ENTREMONT: Maybe this is more of a question for the Auditor General's Office but when developing the recommendations that we had in this document, did you look at other models across the country to see what the best recommendations would be or were you just able to come up with them as you saw the information before you?

MR. LAPOINTE: The general rule when we conduct any of these audits is we try not to do too much comparison with other provinces because, for one thing, the situation is different and another, it's kind of a never-ending path that you can go down. We look at developing audit criteria from whatever standards might be in place but not specifically from practices in other provinces.

MR. D'ENTREMONT: What are the next steps, and I guess we talked about having some of those steps in place by the end of December, but again, where are we with the recommendations held before us, specifically in Cape Breton at this point? How is the department going to be taking their part of the recommendations and implementing them across the province - so maybe you'd start with Cape Breton and then move into the larger issue?

MS. CALVERT SIMMS: What are the next steps? Our next steps are to continue to move forward with implementation of the recommendations and monitoring of the effectiveness of the same; to continue to move forward in creating a culture in which infection prevention and control is everybody's responsibility; to ensure that the public, the board, and the staff have the right information they need at the right time; to be able to make sure that we continue to work toward moving barriers to good infection prevention and control practices; to continue to share lessons learned with others as we go forward, as we release the next report - that will be paramount for us; and to try to develop public confidence that they are safe to come into our district.

MS. RHODENIZER-ROSE: From the department's perspective the Auditor General's Report is certainly the first start, but we are doing a fair bit in addition to following up with those recommendations. Part of our approach in the past has always been to build capacity to support the DHAs and the IWK and to provide resources. What we've seen and heard from our counterparts in the districts is that they're looking for more direction, more of a policy-based approach. So that's what we're looking at moving

forward instead of putting out just guidelines and recommendations, we'll be adding a policy approach to those as well.

Also, looking through a project called IICE - the infrastructure and infection control evaluation project - going into other districts and providing a second pair of eyes to look at infrastructure challenges and some of those that would mitigate against good infection control practices. We talked a little bit about surfaces that weren't intact and equipment that was very difficult to clean so we're helping support those districts in identifying those challenges at a local level and then providing the support that they need, whether it's financial or through evidence and support to remedy those situations.

MR. D'ENTREMONT: What kind of budget line is the department providing for this? As we start doing this work I'm sure we'll find lots of surfaces, we'll find lots of equipment, we'll find - I mean the experience in Cape Breton, even just where bedpans are being disposed of and cleaned, it's not down the hall, it needs to be done a little closer to the patients' rooms. All of these infrastructure issues are quite expensive so how are we going to start rolling that out and making sure that this happens in a timely manner, rather than just waiting until the budget process comes back at you?

MR. RHODENIZER-ROSE: Part of the IICE project is to go in, as I said, and be a second pair of eyes. Actually a lot of the things that we're finding in the districts are low-hanging fruit, they're easily remedied, they can be accomplished within their current budget that we feel they're simple solutions to some of these. We're also looking at other innovative strategies to deal particularly with bedpan waste; you don't always have to go with the Cadillac version to do best practice. So that is something that we're looking at as we go around to the districts and audit these facilities.

I find that most of the districts that we have gone to, and we've gone to eight facilities so far, there are things that they can tick off their to-do list fairly easily, without a lot of requests for additional funding. Anything that's bigger, we're hoping that they can incorporate into their business planning for future years.

MR. D'ENTREMONT: Sort of maybe one final question. I think when Quebec moved its way beyond their issue, it had a lot to do with the public confidence issue as well, making sure that people were comfortable going back to a hospital once again or what the issues were. So if there are any suggestions of Web sites and listings and stuff, how quickly can we move on some of those issues? They are more complicated but from a public confidence standpoint, I think they're going to be extremely important in this day and age. That's more of a statement too.

MS. RHODENIZER-ROSE: Just in addition to the points that you made, IPCNS continues to work with the infection control programs around the district and the IWK. We find that we're sharing a lot of information, whether it's best practice ideas or if it's even educational tools, so there is a fair bit of sharing of information amongst the infection

control practitioners that other districts can utilize. So it's getting that information out to the organizations, also promoting. On district Web sites we have our own Web site for IPCNS so we're doing as much as we can to get the information out to the public.

MR. D'ENTREMONT: How am I doing for time? We should be pretty darn close.

MR. CHAIRMAN: Your time has expired. Mr. MacKinnon.

MR. CLARRIE MACKINNON: Mr. Chairman, I want to begin by saying that I am a former resident of CBRM and I spent many, many days in the regional hospital. I accompanied my wife to all 28 sessions of radiation that she had there, her chemo, and the emergency operation that saved her life, and I want to thank you for second-to-none care that we received there, very sincerely.

Now, having said that, I want to perhaps quote Ms. Calvert Simms: "The mutual aid approach is alive and well in health care across this province . . ." This was in relation to the C. difficile outbreak. Can you perhaps elaborate on that?

MS. CALVERT SIMMS: We very early on in the outbreak recognized that we did not have sufficient resources on the ground to be able to ensure appropriate surveillance, education and monitoring. We had significant help from our colleagues in Infection Prevention and Control Nova Scotia. They spent, I think, about five weeks with us but it still wasn't enough. We reallocated our own internal resources from Public Health and from education but to make sure that we could provide the resources that we need and to do what we needed to do across the whole district health authority, we knew that we needed help.

I put out a call to my colleagues across the province and asked for additional infection prevention and control resources. We secured help from a number of the different district health authorities very, very quickly: Capital Health, IWK, Pictou, and Colchester I believe.

MR. MACKINNON: Thank you very much. I appreciate the member for Halifax Chebucto, who really has the second round here for us, giving me a moment, so thank you, and I turn it over to the member.

MR. CHAIRMAN: Mr. Epstein.

MR. HOWARD EPSTEIN: Mr. Chairman, our government takes patient safety very seriously. We want all patients who arrive at hospitals, who by definition are already having health problems, not to worry about the possibility of health care-associated infections. We're, therefore, very grateful to the Auditor General for having examined the situation that arose in Cape Breton and having given us the benefit of their advice. We join with the Cape Breton District Health Authority and with the Deputy Minister of Health and

Wellness in an expression of profound regret to the individuals and their families who suffered through this. At the same time, of course, we're very focused on what it is that can happen in the future so that we make sure the system works as well as possible, and that really has been the focus of the discussion today.

The first point I wanted to raise is the question of national comparisons. I think that question came up just briefly in passing earlier but I'm wondering if we can have an undertaking from the witnesses that they might supply the committee with some comparative data with respect to HAI matters around the country. I don't know if CIHI, the Canadian Institute for Health Information, collects that particular data or whether it's readily available otherwise, but I'm wondering if we can be supplied with some comparative data that might help us understand a bit more about the context. Is that going to be easily possible to do?

MS. RHODENIZER-ROSE: We can provide you with that data. There isn't a great body of data out there for health care-associated infections across Canada, a Canadian benchmark per se. There is the Canadian Nosocomial Infection Surveillance Program through the Public Health Agency of Canada and they do collect data from certain check sites or certain pre-arranged facilities across the province that submit their data. A lot of times facilities will use those benchmarks to monitor their own in-house infection rates so we can provide you with those for MRSA, VRE, and C. difficile. Some of the other health care-associated infections, we have great difficulty providing any kind of national benchmark.

MR. EPSTEIN: The instances that you just mentioned, are these all reportable infections or diseases in their respective province? Is that why the data is available?

MS. RHODENIZER-ROSE: It certainly is in Nova Scotia.

MR. EPSTEIN: I read that.

MS. RHODENIZER-ROSE: I can't comment on whether they're reportable by law in the other provinces, off the top of my head.

MR. EPSTEIN: Okay, thank you.

MR. MCNAMARA: I just want to add something. I received an e-mail last evening saying that Canadian Public Health was going to be stopping its program of funding the infection control review across the country. That is a concern for us so we will be talking to the Public Health Agency of Canada to ensure that continues, if at all possible.

MR. EPSTEIN: Okay, that will be good, thank you. We look forward to reviewing the information that you can supply.

The next point I wondered about was the topic of best practices. This has been referred to a number of times by all of you. I'm wondering if you can tell us a bit about how it is that best practices are established, whether with respect to HAI - hospital acquired infection - there is one authoritative source for best practices or whether it's an integrative process in which we're always learning. Can I hear a bit about that, please?

MS. RHODENIZER-ROSE: I can say all of the above. There are best practice documents that we utilize in Nova Scotia but I'm quite confident that other practitioners across the country use the same approach. There are CDC documents that we use and there are Public Health Agency of Canada documents that we use. We tend to, in some ways, cherry-pick but they're basically all saying the same thing and they're all based on the latest evidence and the latest science, so a lot of times it's just user-friendliness or readability that we may pick one document over the other. We tend to try to go with the Canadian guidelines but a lot of times some, particularly from the Public Health Agency of Canada, are a little bit out of date.

MR. EPSTEIN: Is it the case with respect to HAI that best practices are generally well established but the bulk of the problem is in compliance?

MS. RHODENIZER-ROSE: I would say yes. A big part of an infection control practitioner's daily work is to continually educate health care workers. The science is constantly changing so it's a matter of updating practices as the evidence becomes available, so it's ongoing.

MR. EPSTEIN: Thank you. I had a specific question about scopes. I heard reference several times to scopes and the necessity for them to be cleaned appropriately and so on, and also that there be some kind of monitoring of that so that people are clear that this has actually occurred and that this can be documented. What I don't think we heard was perhaps a detailed description of how this actually happens in a hospital. What I'm particularly interested in is a little bit more of a look at the process so that it's known by the hospital staff that a scope has been cleaned and that it is ready for use again.

Can you tell us or can someone tell us a bit about how that happens and how it is that people actually know? I did hear from the Auditor General's Office today that there was a question, and it sounded like a serious question, about the ability when they were there to actually find something to document that.

MS. RHODENIZER-ROSE: Scope cleaning actually is a very complex process; it's not a matter of just sort of soaking it in water with some soap and then running a disinfectant through it. It involves some very specific pre-tests, pre-cleaning, going through an automatic endoscope reprocessor that provides, at a minimum, high-level disinfection, and in some cases sterilization. Then there are very specific steps that you have to take after that scope comes out of the machine, to ensure that there's no potential

for bacterial growth once it's stored and also that it is indeed cleaned and disinfected to the standard.

MR. EPSTEIN: Can I just go back a little bit. Once a scope has been used, whose responsibility is it to make sure that it is somehow isolated from other equipment in a room and then taken for a cleaning, who does that?

MS. RHODENIZER-ROSE: The general practice in most districts, if not all, is that once a scope is done and the patient has had their procedure, there's somebody within that endoscopy unit who takes the scope and puts it through that entire cleaning and decontamination process. There's a turnaround time in units - they're very busy - so that's an ongoing thing that occurs throughout the day and throughout the schedule. Once it has gone through, all that cleaning and disinfection and it has been high-level disinfected, then there are printouts and logging and documentation that the person who has done the job has to ensure occur.

MR. EPSTEIN: So there should be documentation, is that what you're saying?

MS. RHODENIZER-ROSE: Absolutely. And to Evangeline's point, if you don't have the documentation, it's not a matter of just not doing the paperwork; there is no way to verify that that scope met either decontamination parameters or that it went through the proper processes.

MR. EPSTEIN: Yes, and in the instances that were described there, can you tell us - or if you know - what the problem was?

MS. RHODENIZER-ROSE: Do you want to take that?

MR. CHAIRMAN: Ms. Calvert Simms, you're going to run out of time here unfortunately. Is that something you would like to get in documentation after today?

MR. EPSTEIN: I think it would be useful if we could have some written commentary on that, it would help a lot. Thank you very much.

MR. CHAIRMAN: Our time for questions has expired and I would ask the deputy minister to make some very brief comments because we don't have a lot of time.

MR. MCNAMARA: I just want to thank the committee for the opportunity to come and talk about the recommendations from the Auditor General. I also want to thank the Auditor General for bringing public attention to this. It is one of the ways that between that and this committee that we can educate the public, that working together we all have a responsibility - including them - to help us prevent infection spreads throughout our facilities. Thank you very much.

MR. CHAIRMAN: We have just a couple things on the list here. Mr. d'Entremont gave me a letter. Mr. d'Entremont, what are your wishes with the letter, what is your request with that?

MR. D'ENTREMONT: It's an issue that I've been dealing with a number of constituents and it sort of came up as an issue as we were talking in caucus. It would be interesting to have a presentation by WCB in regard to safety associations, how they're working, how they're funded, and those kinds of issues. I thought maybe that would be an interesting point for a future meeting so I'd like to maybe have that considered by the subcommittee as a possible topic for discussion.

MR. CHAIRMAN: Great, thank you and I'd like to thank our guests for coming; it has been a very informative session today.

Our next meeting will be November 21st, and I'll just let the members know now that the information for that meeting will be embargoed until the Auditor General's Report is tabled in the Legislature, sometime after 2:00 p.m. Just a reminder to that and we will remind everybody again about that on the 21st.

We have two or three different things here, we've asked for information from the department: Mr. Younger asked for information, and an assignment list of staff was asked for by Mr. Ramey. Do you still want that information, Mr. Ramey, or were you satisfied with the answer?

MR. RAMEY: Yes, I was satisfied with the answer.

MR. CHAIRMAN: Okay, so we don't need that one. There was also a data request by Mr. Epstein from Ms. Rhodenizer-Rose, so that will be supplied too. Thank you very much.

A motion to adjourn is in order.

MR. WHYNOTT: Mr. Chairman, I so move.

MR. CHAIRMAN: We stand adjourned.

[The committee adjourned at 10:58 a.m.]