



SOUTHWEST IPAC HUB

Spring Newsletter 2025

WHAT IS THE IPAC HUB?



The Southwest IPAC Hub is a collaboration between **Middlesex-London Health Unit**, the **Huron Perth Public Health** and **Southwestern Public Health**. We provide advice, guidance and direct supports to IPAC leads and those responsible for IPAC in congregate living settings including Long-Term Care Homes, Retirement Homes, Group Homes, Shelters, Supportive Housing.

Our team works collaboratively with partners to provide the following IPAC services and supports:

- Development of education and training programs and materials
- Supportive visits and consultations
- Assistance with IPAC self-assessments
- Coaching/mentoring on IPAC practices
- Outbreak management planning
- Communities of Practice (CoP)
- Best practice recommendations and implementation support



WHAT SERVICES DO WE PROVIDE?

In this issue:

- **World Hand Hygiene Day – May 5th**
- **Upcoming Webinars**
- **Double Trouble: Norovirus and Influenza on the Rise—What You Need to Know**
- **Candida Auris**
- **Chickenpox vs. Shingles vs. Measles**

Upcoming Communities of Practice (CoP)

MLHU & SWPH IPAC Hub CoPs	Huron Perth IPAC Hub CoPs
For LTCH/RH April 29, May 27, June 24 at 1pm	For LTCH/RH April 9, May 7, June 11 at 11am
For CLS April 17, June 19 at 11am	For CLS April 4, May 2, June 6 at 10am

May 5th is [World Hand Hygiene Day](#).



Hand hygiene is the most effective way to prevent the transmission of healthcare associated infection to residents,

patients, staff, and visitors in all healthcare settings. Hand hygiene is an essential element of patient safety for the prevention of infections and the spread of antimicrobial resistance.

Hand hygiene should always be performed in the following situations:

- Before contact with a patient or patient's environment
- Before a clean or aseptic procedure
- After exposure or risk of exposure to blood and/or body fluids
- After contact with a patient or patient's environment

Additionally, hand hygiene is performed before putting on gloves and immediately following the removal of gloves.

Healthcare workers often experience dry and cracked hands due to frequent hand washing and sanitizing. Maintaining the integrity of your skin is crucial for both your safety and the patient's, as non-intact skin harbours a higher number of organisms. It is essential to ensure that your hands remain healthy, with intact and irritation-free skin.

Public Health Ontario (PHO) offers a valuable resource for healthcare providers to assess and identify skin problems and their causes. This will enable you to proactively protect your hands from skin breakdown:

[Protecting your Hands Fact Sheet for Healthcare Providers](#)

[Caring for your hands poster](#)

Webinars

- Upcoming:

- **April 22:** [Webber Teleclass](#) - Cost Analysis of a Hand Hygiene Improvement Strategy in Long-Term Care Facilities with Dr. Anja Haenen, Netherlands
- **April 24:** [Webber Teleclass](#) - What's Lurking in Your Sinks? Past Problems, Present Challenges, and Future Technologies with Dr. Mark Garvey, UK
- **May 5:** [Webber Teleclass](#) - Special Lecture for World Hand Hygiene Day

- In case you missed it:

- **Infection Prevention and Control Surveillance Workshop for Long Term Care**
 - [Recording](#)
 - [Participants Workbook](#)
 - [Presentation Handouts](#)
- **Voices of Care: Insights from LTCH Support Workers' Survey Results**
 - [Recording](#)
 - [Presentation Handouts](#)
- **Candida auris: A New Disease of Public Health Significance Management of this Highly Transmissible Fungal Pathogen**
 - [Presentation Handouts](#)
- **Antibiotic Resistant Organisms: Time for a Rewind**
 - [Presentation Handouts](#)
- **What CAN Antibiograms Tell us? Microbiological insights for antimicrobial stewardship**
 - [Recording](#)

Important Dates

May 5, 2025: World Hand Hygiene Day. Theme: It might be gloves. It's always hand hygiene. For more information and resources: www.who.int/campaigns/world-hand-hygiene-day/2025

New & Updated Resources

[Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings](#)

[Infection Prevention and Control for Home and Community Care](#)

[Infection Prevention and Control for Home and Community Care: Quick Reference](#)

Double Trouble: Norovirus and Influenza on the Rise—What You Need to Know

Influenza and Norovirus Activity in Ontario

This winter, Ontario has experienced notable activity levels for both influenza and norovirus.

Influenza Activity		
According to Public Health Ontario's Respiratory Virus Tool, there was a marked increase in laboratory-confirmed influenza cases during the 2024-2025 season-to-date compared to previous seasons. For more information: www.publichealthontario.ca/en/Data-and-Analysis/Infectious-Disease/Respiratory-Virus-Tool		
Norovirus Activity		
Norovirus, often referred to as the "winter vomiting bug," also saw increased activity this winter. The Public Health Agency of Canada reported a spike in norovirus cases, reaching a five-year high. This increase was observed across multiple provinces, including Ontario.		
Differences Between Influenza and Norovirus		
Feature	Influenza	Norovirus
Cause	✓ Influenza virus (most commonly types A and B)	✓ Norovirus
Transmission	✓ Respiratory droplets ✓ Contact with contaminated surfaces	✓ Fecal-oral route ✓ Contaminated food or water ✓ Direct contact with infected individuals
Symptoms	✓ Fever, chills ✓ Cough, sore throat, congestion ✓ Muscle aches, headaches ✓ Fatigue	✓ Nausea ✓ Vomiting ✓ Diarrhea ✓ Stomach cramps
Onset	✓ Sudden, usually within 1-4 days of exposure	✓ Rapid, usually within 12-48 hours of exposure
Duration	✓ 5-7 days (can be longer in vulnerable populations)	✓ 1-3 days
Complications	✓ Pneumonia, respiratory failure, hospitalization, death (especially in older adults and those with chronic conditions)	✓ Dehydration, electrolyte imbalance, malnutrition (especially in young children and older adults)
Treatment	✓ Antiviral medications (e.g., Tamiflu), supportive care	✓ Supportive care (hydration, electrolyte replacement)
Prevention	✓ Annual flu vaccine ✓ Hand hygiene ✓ Masking ✓ Respiratory etiquette ✓ Cleaning and disinfection of high-touch surfaces with your routine health-care grade disinfectant	✓ Handwashing ✓ Cleaning and disinfection of high-touch surfaces with high-level disinfectant ✓ Proper food handling

Impact of Influenza and Norovirus Infections in Congregate Living Settings

Congregate settings are at high-risk influenza and norovirus outbreaks due to **close quarters, shared spaces, and vulnerable populations**. Being prepared to manage influenza and norovirus outbreaks is critical because:

1. Rapid Spread

- ✓ Both viruses spread very quickly in enclosed spaces, leading to widespread illness in a short time.

2. Vulnerable Populations

- ✓ Older adults, immunocompromised individuals, and those with chronic conditions are at higher risk of severe complications such as pneumonia or death from influenza and dehydration from norovirus.

3. Strain on Staffing

- ✓ High infection rates can lead to absenteeism among staff.

4. Legal and Ethical Responsibilities

- ✓ Congregate living settings have a duty to protect residents/clients, employees, and visitors through infection control measures.

5. Economic and Operational Impact

- ✓ Outbreaks can result in increased costs and disruptions to daily operations.

Would you like support with outbreak planning and preparation, contact your local health unit.

References:

www.publichealthontario.ca/en/Data-and-Analysis/Infectious-Disease/Respiratory-Virus-Tool

www.canada.ca/en/public-health/services/food-poisoning/norovirus.html

www.ontario.ca/files/2025-02/moh-recommendations-for-outbreak-prevention-and-control-in-institutions-and-clis-en-2025-02-28.pdf

Candida Auris

Since its identification in 2009, *C. auris* has emerged as a significant public health threat due to its ability to cause outbreaks in health care settings and its resistance to multiple classes of antifungal medications. Outbreaks have been documented in ICU's and long-term care facilities. *C. auris* is known for its persistence on surfaces and in the environment, increasing its transmission risk among vulnerable populations. Cases of *C. auris* have been reported in Ontario and are likely to increase resulting in the overall burden of disease to increase as well.

For more information and resources, visit [Candida auris | Public Health Ontario](#)

NEW *C. auris* is reportable

Due to the emerging threat in Ontario, *C. auris* is now considered to be a reportable disease which means that all *C. auris* infections must be reported to your local health unit for case and contact investigation and follow up.

Only infections are reportable, not colonization. However, a colonization is a good opportunity to have a discussion with your local health unit to discuss how to manage.

Who is at risk for *C. auris* infection?

- **Severe underlying medical conditions** who require complex medical care
- **Invasive medical devices** (breathing tubes, feeding tubes, catheters, etc)
- History of **long-term overuse of antibiotics and/or antifungals**
- **Admission to a hospital or LTC home outside of Canada**
- **Transfer from a healthcare facility with an ongoing outbreak of *C. auris***

What can facilities do to prepare:

All facilities should have policies and procedures in place for screening and care of residents who are colonized with *C. auris*.

Prompt identification of risk factors, screening and contact precautions are all measures that facilities must take to prevent the transmission of *C. auris* within your facility.

https://www.publichealthontario.ca/-/media/Documents/A/24/antibiotic-resistant-organism-risk-factor-screening-guide.pdf?rev=4387e8099b104984b927d653a0278104&sc_lang=en

For screening and testing instructions refer to PHO's testing information sheet

Mycology – Candida auris | Public Health Ontario

Interim Guide for Infection Prevention and Control of Candida auris

Management of a Single New Case of Candida Auris (C. auris)

Environmental cleaning and disinfection:

Due to its persistence, contamination of the environment, medical equipment and other fomites are believed to play a role in *C. auris* transmission.

Rigorous attention to environmental cleaning may be important to prevent the transmission within the facility. Disinfectants such as sodium hypochlorite (bleach) or enhanced hydrogen peroxide (0.5%, 1.4%) are effective agents against *C. auris*. Quaternary compounds are not effective and should not be used for disinfection of the environment or medical equipment potentially contaminated with *C. auris*.

Rooms with residents who are colonized or infected with *C. auris* should be cleaned and disinfected at least daily (minimum). Some research suggests that twice daily cleaning/disinfection is better.








Other resources:

Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition

Best Practices for Hand Hygiene in All Health Care Settings, 4th edition



Chickenpox vs. Shingles vs. Measles

Feature	Chickenpox (Varicella)	Shingles (Herpes Zoster)	Measles (Rubeola)
 Cause	Primary infection from varicella-zoster virus	Reactivation of varicella-zoster virus	Measles virus
 Transmission	Direct contact, droplet, or airborne spread of fluid from vesicles or respiratory secretions	Direct contact with fluid from blisters. You cannot get shingles from someone who has shingles, but you can get chickenpox if not immune.	Highly contagious. Airborne, close personal contact, or direct contact with the respiratory secretions.
 Symptoms	Mild fever, headache, runny nose, malaise, and a generalized itchy vesicular rash that progresses rapidly.	Painful, blistering rash. Pain, itching, or tingling may occur in the area before the rash develops. May be accompanied by fever, headache, upset stomach.	High fever, cough, runny nose, red eyes, and generalized maculopapular or macular rash. Koplik spots (tiny blue-white spots in the mouth) may be present.
 Rash	Itchy rash on all areas of the body. Rapidly evolves from macules to papules, vesicles, and then crusts. May occur in crops so many stages are present at once.	Blistering rash that usually occurs only on one side of the body or face, often in a stripe. Rarely may become more widespread (disseminated).	Macular or maculopapular non-itchy rash that begins on the face and then spreads down the body. In severe cases, rash may join so that the skin is completely covered.
 Contagious Period	2 days before rash onset and until all lesions are crusted, usually about 5 days after rash onset	Until rash crusts over and dried.	4 days before rash onset to 4 days after rash onset
 Prevention	Varicella vaccination, if eligible	Shingles vaccination (recommended for adults 50+). Publicly funded for adults between 65-70.	MMR vaccination, if eligible
 Precautions/PPE	Airborne, and contact: Fit-tested and seal-checked	Routine Practices: : cover rash, hand hygiene. Airborne	Airborne: Fit-tested and seal-checked N95 respirator with

	N95 respirator, eye protection, gown, gloves	precaution is recommended for disseminated shingles and for immunocompromised clients/residents	addition of eye protection, gown, and gloves as per PCRA.
⚠ Risk to LTC /RH/CLSResidents/ Clients	Can occur in anyone not previously infected or vaccinated. Secondary infections, such as pneumonia and encephalitis. Virus remains latent in the body and can reactivate as shingles.	Severe pain, infected lesions, and very rarely more serious secondary infections. May result in severe long-term nerve pain or vision loss if the eyes are affected.	Highly contagious and can spread to anyone not protected by vaccination or previous infection (individuals born before 1970 are considered to have natural immunity). Can lead to secondary infections such as pneumonia, otitis media, and measles encephalitis.

Tips for LTC/RH/CLS Staff

- ✓ Ensure residents and staff are up to date on **shingles, chicken pox, and MMR vaccines** if eligible.
- ✓ Use **proper infection control** measures (hand hygiene, PPE, isolation if indicated).
- ✓ Educate staff and residents on **early symptom recognition**.
- ✓ Chickenpox and measles are reportable to public health. Report suspected and confirmed **measles and chickenpox cases immediately**.

References:

[Appendix 1: Case Definitions and Disease Specific Information Disease: Chickenpox \(Varicella\)](#)

[Government of Canada-Varicella \(Chickenpox\)](#)

[CDC-Shingles \(Herpes Zoster\)](#)

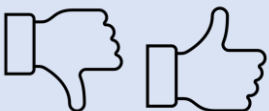
[Appendix 1: Case Definitions and Disease Specific Information Disease: Measles](#)

[Government of Canada-Notice: Updated infection prevention and control recommendations for measles in healthcare settings](#)

[Public Health Ontario-Routine Practices and Additional Precautions In All Health Care Settings, 3rd edition](#)

Contact your local IPAC hub: [Huron Perth Public Health](#), [Middlesex London Health Unit](#) or [Southwestern Public Health](#)

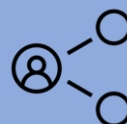
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Do you have a service request?



Do you have an IPAC story to share?



Do you have general feedback or suggestions?

