



Infection Prevention and Control Required Safety Practices

August 2026

Infection Prevention and Control Required Safety Practices

- Cleaning and Low-Level Disinfection of Medical Equipment
- Improving Hand Hygiene Practices
- Health Care-Associated Infection Surveillance

By the end of this session, participants will:

- Understand each of the Required Safety Practice (RSP)
- Be prepared to answer surveyor questions
- Know where to find policies, procedures, tools and resources



Definitions

Organizational Leaders

Leaders at all levels, including directors, managers, supervisors, clinical leaders, and others who have leadership responsibilities within the organization.

Team

People collaborating to meet the goals, needs, and preferences of the client. The team includes the client; designated support person(s); and workforce members involved in the client's care. Depending on the care provided, the team may also include organizational leaders, volunteers, learners, external service providers, and visitors



Improving Hand Hygiene Practices

Required Safety Practice

Hand Hygiene

Hand hygiene is one of the most effective ways to prevent the spread of infection in healthcare settings.

- Hands are a common route for transmission of microorganisms between patients, equipment, and the environment.
- Proper hand hygiene helps break the chain of infection and reduce the risk of healthcare-associated infections.
- Effective hand hygiene protects patients, visitors, and team members.
- Consistent hand hygiene practices support safer care, outbreak prevention, and improved patient outcomes.
- Every team member plays a role in reducing infection transmission through appropriate hand hygiene practices.

Our Approach



NS Health supports hand hygiene improvement through leadership commitment, accessible resources, continuous learning, monitoring, and quality improvement.

Standardized Procedures

- IPC-RP-020 Hand Hygiene Policy
- Four Moments of Hand Hygiene

Resources

- Hand Hygiene Champions
- IPAC consultation and support
- Hand Hygiene sinks and ABHR dispensers

Education

- LMS education
- Safety huddles

Monitoring and Improvement

- Hand Hygiene Audits
- Walk-arounds
- Safety reporting
- Hand Hygiene dashboard, Unit Based Reports
- Quality improvement activities
- Operational Excellence Management System (OEMS)

0.4 Improving Hand Hygiene Practice

0.4.1 The organizational leaders and teams collaborate to improve hand hygiene practices.



0.4.1.1 The organizational leaders define an aim for improving hand hygiene practices

The **aim**:

- Is focused on a measurable outcome
- Articulates targeted improvement over a specified time frame
- May consider improving hand hygiene practices in all care, administrative, and public settings across the organization;
- May be defined collaboratively with partners and informed by baseline data on hand hygiene compliance;
- May be documented in the hand hygiene quality improvement plan

 Policy & Procedure		
Policy Title:	Hand Hygiene	
Applies To:	All Nova Scotia Health Team Members	
Approved:	Effective:	Next Review:
Oct. 18, 2021	Oct. 19, 2021	Oct. 18, 2025
Sponsor:	Senior Director, Quality Improvement and Safety	
Approval Authority:	VP, Quality and System Performance	
Number:	IPC-RP-020	Manual: Infection Prevention and Control

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0.4.1.1 Potential Surveyor Questions:

- Are you aware of any hand hygiene improvement goals or targets in your unit?
- Do you know your unit's most recent hand hygiene compliance rate?
- Where can you find hand hygiene performance data?



0.4.1.1 Evidence Examples:

- Documented hand hygiene improvement aim
- Baseline hand hygiene compliance data used to inform the aim
- Performance dashboards, scorecards, or reports tracking progress toward the aim

Hand Hygiene Compliance by Zone

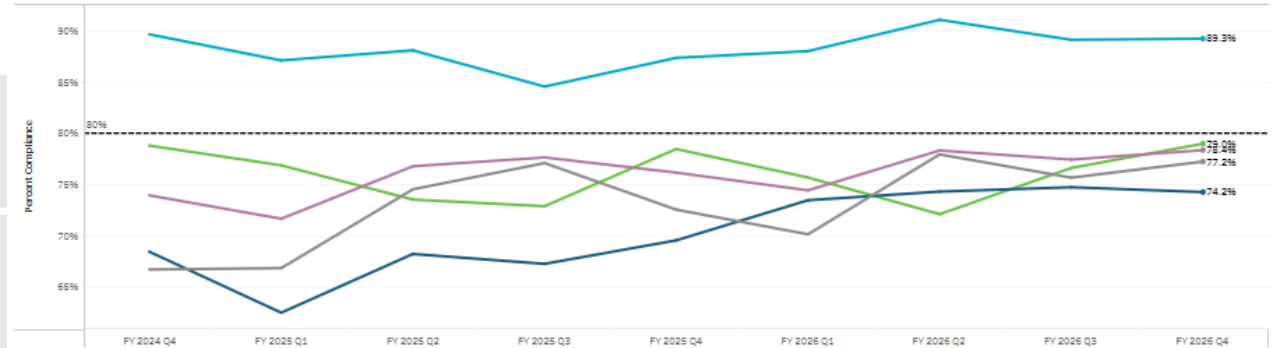
The chart below displays the percent compliance for 'Before Patient Contact-Moment 1' for NSH Zones.

Zone
Central Zone
Eastern Zone
Northern Zone
Western Zone

Zone Filter:
☒ (All)
☒ Central Zone
☒ Eastern Zone
☒ Northern Zone
☒ Western Zone

Site Filter:
☒ (All)
☒ Aberdeen Regional
☒ Addictions (Pictou)
☒ All Saints Springhill
☒ Annapolis Community
☒ Bayers Lake Comm Outpt Ce...
☒ Bayview Memorial
☒ Braeside Nursing Home
☒ Buchanan Memorial
☒ Cape Breton Regional
☒ Cobequid Community Health
☒ Colchester East Hants Health
☒ Cumberland Regional
☒ Dartmouth General
☒ Digby General
☒ East Coast Forensic Hospital
☒ Eastern Memorial
☒ Eastern Shore Memorial
☒ Fishermen's Memorial
☒ Glace Bay Memorial
☒ Guysborough Memorial
☒ Halifax Infirmary

Before Patient Contact - Moment 1 Compliance by Zone: All



Before Patient Contact - Moment 1 Compliance by Zone: All

Zone	FY 2024 Q4	FY 2025 Q1	FY 2025 Q2	FY 2025 Q3	FY 2025 Q4	FY 2026 Q1	FY 2026 Q2	FY 2026 Q3	FY 2026 Q4
Central Zone	66.7%	66.8%	74.5%	77.1%	72.5%	70.1%	77.9%	75.7%	77.2%
Eastern Zone	68.4%	62.4%	68.2%	67.2%	69.5%	73.5%	74.3%	74.7%	74.2%
Northern Zone	78.8%	76.9%	73.5%	72.9%	78.5%	75.7%	72.1%	76.6%	79.0%
Western Zone	89.7%	87.1%	88.1%	84.6%	87.4%	88.0%	91.1%	89.2%	89.3%

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Prepared by: Nova Scotia Health Performance and Analytics

0.4.1.2, 0.4.1.3 The organizational leaders invest in resources to improve hand hygiene practices and provide teams with access to continuous learning on improving hand hygiene practices

Resources include members of the workforce, finances, infrastructure, equipment, and information.

Resources may include:

- a person or team that has the responsibility and protected time to improve HH practices;
- Accessible HH infrastructure, including sinks and ABHR dispensers; and
- Processes to collect, monitor, and analyze HH compliance data
 - Direct observation
 - Electronic monitoring systems

Learning topics may include:

- proper handwashing techniques and use of ABHR;
- four moments of hand hygiene;
- infection transmission and breaking the chain of infection;
- avoidance of artificial nails; and
- Hand hygiene improvement initiatives and outcomes

Providing learning activities in various ways may help engage team members with different educational backgrounds, abilities, and learning styles.

0.4.1.2, 0.4.1.3 Potential Surveyor Questions:

Resources:

- Are hand hygiene supplies readily available where you provide care?
- What would you do if an ABHR dispenser was empty or a sink was not functioning?
- How do you monitor the availability and accessibility of sinks and ABHR dispensers?
- Who would you notify if hand hygiene resources were unavailable?

Continuous Learning

- Can you describe the Four Moments for Hand Hygiene?
- What hand hygiene topics are included in education programs?
- How do patients, families, and visitors receive education about hand hygiene?
- Can you show me examples of hand hygiene education materials available to staff?



0.4.1.2, 0.4.1.3 Evidence Examples:

Resources:

- Identified hand hygiene champion
- Readily accessible hand hygiene infrastructure, including:
 - Functional sinks
 - Soap and paper towel dispensers
 - Alcohol-based hand rub (ABHR) dispensers at point of care and key locations
- Routine audits of ABHR placement
- Hand Hygiene Compliance Reports

Continuous Learning

- Orientation records demonstrating hand hygiene education for new staff
- Learning Management System (LMS) completion reports
- Hand Hygiene posters and visual reminders
- Newsletters, campaigns, educational materials
- Safety Huddles for Hand Hygiene
- Team Members are able to describe the Four Moments of Hand Hygiene



Hand Hygiene Action Plan Report

Zone - Choose an item.

Facility - Click here to enter text.

Unit/Program - Click here to enter text.

Responsible Director - Click here to enter text.

Reporting Period - Choose an item. Click here to enter text.

Hand Hygiene Rate - Click here to enter text.

Moment - Choose an item.

Reported By - Click here to enter text.

Nova Scotia Health, in accordance with the Health Protection Act, is required to report on the performance of its hand hygiene program which monitors patient, patient environment and visitor hand hygiene (Moment 4).

This Hand Hygiene Action Plan unit or program shows decline in Moment 4. We recognize that can be dependent on many factors and we will continue to discuss around opportunities for improvement.

Alcohol Based Hand Rub Placement Checklist

Proper placement of ABHR is essential to promote hand hygiene compliance, reduce the risk of healthcare-associated infections, and ensure safety for patients/residents/clients, team members, and visitors. Refer to [Placement of Alcohol-Based Hand Rubs and Hand Lotion Dispensers Practice Guidance](#) on the IPAC Compass Site.

#	Item	Compliance?		Comments
		Yes	No	
General Unit Accessibility				
1	ABHR dispensers are located near or easily accessible to the nurse's station and substation.			
2	ABHR is located at all entrances and exits of the unit.			
3	ABHR dispensers are not located immediately next to soap dispensers.			
4	ABHR dispensers are clearly labelled and easily distinguished			
Point of Care and Patient/Resident/Client Areas				
5	ABHR dispensers are located at the point-of-care in all areas where care is provided.			
6	ABHR dispensers are securely mounted on outside of the entrance of each patient, resident, or client bedroom.			
7	ABHR is present within comfortable reach of each glove box holder to allow hand hygiene when gloves are donned or doffed.			
8	ABHR is located within comfortable reach of each Workstation on Wheels (WOWs).			
9	ABHR dispensers are located in recreation or activity rooms.			
10	ABHR dispensers are located in rehabilitation or gym areas.			
11	ABHR dispensers are located in common area/lounge spaces.			
Non-Patient/Resident/Client areas				
12	ABHR dispensers are located in medication rooms.			
13	ABHR dispensers are located in soiled utility rooms			
14	ABHR dispensers are located in clean utility/storage rooms.			
Safety and Ergonomics				
15	ABHR dispensers are not blocked by movable objects (e.g., supply carts, equipment).			
16	ABHR dispensers are not near ignition sources (electric outlet or switch)			
17	ABHR dispensers are at a height suitable for comfortable reach (approximately 1 m from the floor).			
18	ABHR dispensers are placed to minimize splashing or dripping onto walls and floors to prevent damage and fall hazards.			

0.4.1.4, 0.1.4.5 The organizational leaders maintain a hand hygiene continuous quality improvement plan and measure and monitor the effectiveness of the plan

A continuous quality improvement plan provides essential information about how hand hygiene improvement activities will be implemented, managed, and evaluated. HH continuous improvement activities include:

- Visual reminders and cues;
- Hand hygiene champions;
- Optimal placement of HH supplies and equipment
- Approaches to identify where supplies are needed such as use of visual indicators;
- HH auditing such as observational monitoring and electronic monitoring systems; and
- Performance feedback such as on-the-spot feedback, team huddles, visual displays, and electronic dashboards.

The effectiveness of the hand hygiene continuous quality improvement plan may be measured and monitored through:

- **structural indicators** relating to hand hygiene infrastructure and the availability of hand hygiene supplies and equipment such as sinks and alcohol-based hand rub dispensers;
- **process indicators** such as compliance with the organizational procedure on performing hand hygiene; and
- **outcome indicators** such as the use of alcohol-based hand rub and soap, improved hand hygiene practices, decreased infection rates, and qualitative feedback on the user experience.

0.4.1.4, 0.4.1.5 Potential Surveyor Questions:

- How is hand hygiene compliance monitored?
- How are hand hygiene audit results shared with staff?
- What happens when hand hygiene compliance falls below target?
- How are staff engaged in identifying opportunities to improve hand hygiene practices?
- What hand hygiene improvement activities are currently taking place in your area?
- How do you know whether hand hygiene practices are improving in your area?
- How are hand hygiene audit results used to drive improvement?
- How are concerns about hand hygiene supplies or infrastructure reported?
- Can you describe any changes that were made as a result of hand hygiene audit findings?

Hand Hygiene Compliance Rates by Zone

Hand hygiene compliance before contact with a patient or their environment **increased** in Northern Zone over the last 2 quarters, nearing the **80% target**. Compliance after contact with a patient or their environment continued to remain **above target** in all four zones.



Figure 1: Percentage of time healthcare workers perform proper hand hygiene before contact with a patient or their environment (Moment 1) and after contact with a patient or their environment (Moment 4).

Nurturing a Culture of Continuous Quality Improvement

Hand hygiene is the single most effective strategy to reduce the transmission of infection in health care settings. NSH draws on a variety of resources to assist with hand hygiene compliance.

- [Infection Prevention and Control Hand Hygiene](#) module in [IMS](#)
- Hand hygiene resources can be found on COMPASS: [Infection Prevention and Control - Hand Hygiene](#)

Motivations is a key factor in changing behaviour. In communicating surveillance results, we recognize units or areas that are consistently at or above target as well as those making marked improvements towards target.

- **Central Zone** has dedicated hand hygiene monitors – their constant presence paired with focused education prompts behaviour change and improved hand hygiene.
- **Eastern Zone** has hand hygiene auditors who support units with staff education and monitoring to nudge hand hygiene compliance for Moment 1 toward the 80% target.

0.4.1.4 , 0.4.1.5 Evidence Examples:

- Documented action plans developed in response to audit findings
- Hand hygiene posters and signage in clinical and public areas
- Point-of-care reminders promoting the Four Moments of Hand Hygiene
- Designated hand hygiene champions or unit representatives
- Accessible ABHR dispensers and hand hygiene supplies
- Audit reports, dashboards, and quality boards
Team Members can describe recent hand hygiene initiatives
- Hand Hygiene improvement projects



0.4.1.6 Teams conduct benchmarking to identify opportunities for improving hand hygiene.

Benchmarking compares:

- results over time
- data across zones, facilities, and units
- data available through provincial or national benchmarks

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NSH Hand Hygiene Rates by Facility/Unit

Northern Zone - Quarter 4 (Jan 01, 2026 — Mar 31, 2026)

Moment 1 Color Legend

- Target achieved (>=80%)
- Needs additional focus (65 to <80%)
- Requires improvement (<65%)

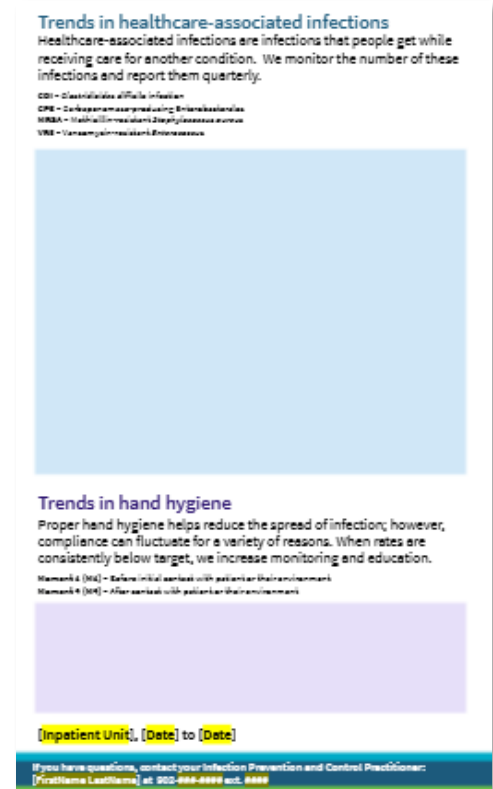
Facility/Unit	MOMENT 1: (before Pat/Env)	MOMENT 4: (after Pat/Env)	BOTH MOMENTS (combined)
Colchester East Hants			
D1 Medical - CEHHC	18/19 94.7%	30/33 90.9%	48/52 92.3%
Renal Dialysis - CEHHC	25/27 92.6%	25/27 92.6%	50/54 92.6%
Women's And Children's Hlth - CEHHC	44/50 88.0%	46/50 92.0%	90/100 90.0%
IMCU - CEHHC	22/26 84.6%	30/33 90.9%	52/59 88.3%
D1 Inpt Mental Health - CEHHC	11/13 84.6%	10/17 58.8%	21/30 70.0%
Palliative Care Unit - CEHHC	26/31 83.9%	33/36 91.7%	59/67 88.3%
Emergency - CEHHC	16/20 80.0%	21/30 70.0%	37/50 74.0%
Ambulatory Care - CEHHC	11/15 73.3%	14/17 82.4%	25/32 78.1%
SJ Surg/Comm Trans Unit - CEHHC	18/25 72.0%	35/43 81.4%	53/68 77.9%
SJ Medical/Stroke Unit - CEHHC	19/27 70.4%	45/56 80.4%	64/83 77.1%
Intensive Care Unit - CEHHC	16/24 66.7%	34/39 87.2%	50/63 79.4%
Facility Total:	226/277 81.6%	313/371 84.4%	539/648 83.2%
Shiloh Fraser Memorial			
Medical Unit - SFMH	48/68 70.6%	59/65 90.8%	107/133 80.5%
Facility Total:	48/68 70.6%	59/65 90.8%	107/133 80.5%
Cumberland Regional			
Renal Dialysis - CR	30/30 100.0%	30/30 100.0%	60/60 100.0%
Transitional Care - CR	14/17 82.4%	15/16 93.8%	29/33 87.9%
Med/Surg - CR	17/22 77.3%	17/22 77.3%	34/44 77.3%
Medical B - CR	21/28 75.0%	22/25 88.0%	43/53 81.1%
Maternity/Child Unit - CR	12/16 75.0%	16/16 100.0%	28/32 87.5%
Emergency - CR	63/85 74.1%	57/82 69.5%	120/167 71.9%
ICU - CR	18/25 72.0%	29/29 100.0%	47/54 87.0%
Facility Total:	175/223 78.5%	186/220 84.5%	361/443 81.5%
All Saints Springhill			
CEC - ASSH	32/34 94.1%	31/32 96.9%	63/66 95.5%
Renal Dialysis - ASSH	41/47 87.2%	48/48 100.0%	89/95 93.7%
Restorative Care - ASSH	49/70 70.0%	69/70 98.6%	118/140 84.3%
Facility Total:	122/151 80.8%	148/150 98.7%	270/301 89.7%
North Cumberland Memorial			
Nursing Unit - NCMH	10/12 83.3%	18/18 100.0%	28/30 93.3%
Facility Total:	10/12 83.3%	18/18 100.0%	28/30 93.3%
South Cumberland			
LTC - SCCOC	28/29 96.6%	25/25 100.0%	53/54 98.1%
Facility Total:	28/29 96.6%	25/25 100.0%	53/54 98.1%
Bayview Memorial			
LTC - BMHC	19/22 86.4%	22/22 100.0%	41/44 93.2%
Facility Total:	19/22 86.4%	22/22 100.0%	41/44 93.2%
Aberdeen Hospital			
MH Short Stay - AH	25/29 86.2%	39/41 95.1%	64/70 91.4%
2 Med/Telco	39/49 79.6%	43/47 91.5%	82/96 85.4%
Emergency - AH	39/50 78.0%	40/46 87.0%	79/96 82.3%
4 Medicine - AH	46/59 78.0%	57/57 100.0%	103/116 88.8%
Facility Total:	149/187 79.8%	179/191 93.7%	328/386 84.9%

0.4.1.7 The organizational leaders demonstrate continuous improvement in hand hygiene practices as evidenced by outcomes.

Continuous improvement may include:

- Implementing new approaches to improve HH practices,
- Streamlining processes to reduce risk and harm
- Maintaining HH improvement plans and continuous learning activities
- Sharing lessons learned

Outcomes may be decreased health care-associated infections, surgical site infections, and reduced length of stay.



0.4.1.6, 0.4.1.7 Potential Surveyor Questions:

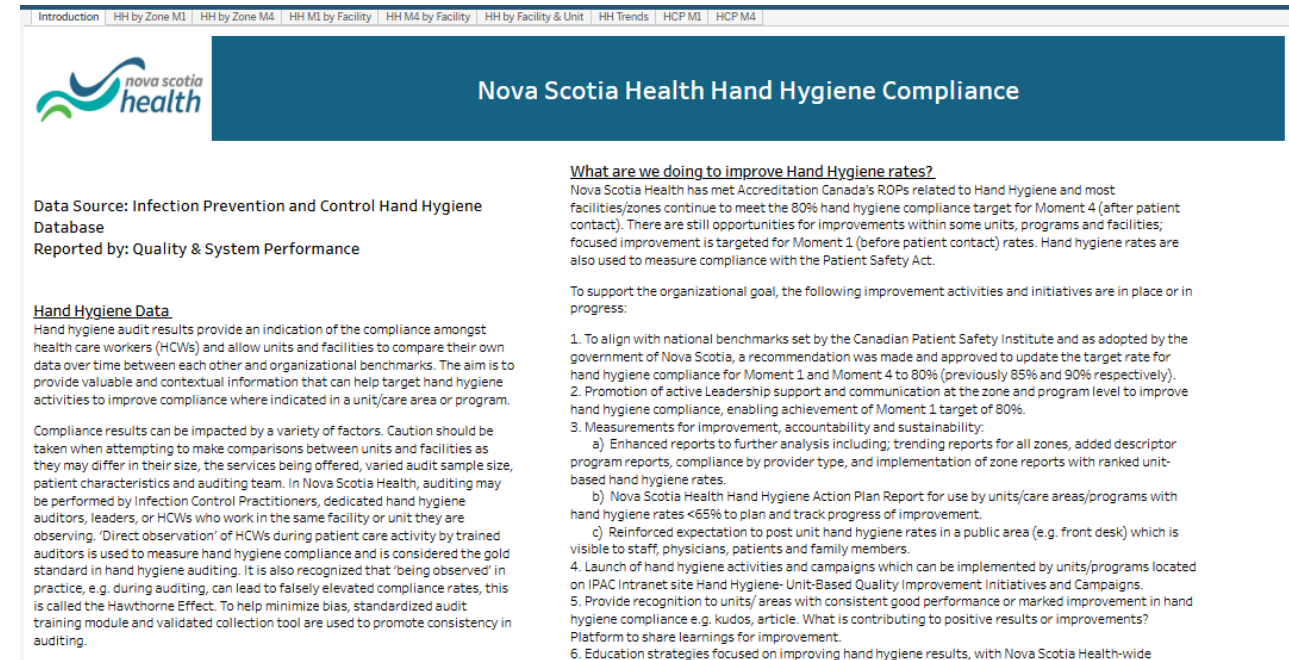
- How do you use benchmarking results to identify improvement opportunities?
- Are hand hygiene results compared across units, sites, or services?
- What do you do when results fall below target?
- How do you identify opportunities for improvement?
- What hand hygiene improvement initiatives have been implemented recently?
- How do you know your improvement efforts are working?
- How are improvements sustained and discussed within the team?

Table 1: Comparison against Target for Provincial-level Indicators Required Under the Patient Safety Act

Patient Safety Act	Target	2025/26			
		Q1	Q2	Q3	Q4
Hand Hygiene (higher is better – aim to be at or above target)					
Compliance rate before patient contact (Moment 1) was relatively stable over the fourth quarter, nearing target	80%	74.4%	78.8%	77.6%	78.5%
Compliance rate after patient contact (Moment 4) continues to exceed target	80%	88.1%	90.0%	89.0%	89.3%

0.4.1.6, 0.4.1.7 Evidence Examples:

- Internal benchmarking reports comparing:
 - Units, programs, sites, or departments
 - Compliance rates over time
 - Performance against organizational targets
 - Trend graphs showing performance over time
- Dashboards, scorecards, or trend reports demonstrating comparison of results
- Action plans developed in response to benchmarking findings
- Demonstrated improvement in hand hygiene compliance rates over time
- Staff and leaders can describe specific improvements made, the results achieved, and how outcomes are being sustained



Operational Excellence Management System

- Hand Hygiene Compliance Rates and Action Plans
- Ongoing review of Team Member education and training
- Number of reported issues or safety concerns related to equipment hand hygiene
- Unit-based discussions at safety huddles and tiered meetings
- Follow-up on identified gaps through action plans and quality improvement activities



Available IPAC Tools and Resources

- Infection Control Practitioners
- Hand Hygiene Auditors
- [IPC-RP-020 Hand Hygiene Policy](#)
- [IPAC Compass Hand Hygiene Page](#)
 - Auditing Program Resources
 - HH Observation Tool
 - HH Auditing Manual
 - Safety Huddles
 - Signage and Posters
 - Quality Improvement Resources
 - HH Action Plan Report
 - Hand Hygiene Toolkit
- Safety Huddles
 - *Topics include:*
 - Client, Family, and Visitor Education
 - Constructive Feedback
 - Maintaining Healthy hands
 - Visual Reminders
 - LMS course:
 - *Hand Hygiene (Code 0204)*
 - [Hand Hygiene Patient Pamphlet](#)



Health Care-Associated Infection Surveillance

Required Safety Practice

Health Care-Associated Infection (HAI) Surveillance

HAI surveillance helps identify infection risks, monitor trends, and guide actions to prevent transmission and harm.

- Surveillance supports the early identification of HAIs, outbreaks, and emerging risks.
- Timely reporting and analysis help prevent the spread of infection and support rapid intervention.
- Surveillance findings inform IPAC measures, education, and quality improvement activities.
- Monitoring infection trends helps evaluate the effectiveness of prevention strategies and identify opportunities for improvement.
- Sharing surveillance information helps teams make informed decisions and improve patient safety outcomes.

Our Approach



Ongoing surveillance helps identify healthcare-associated infections, monitor trends, support timely interventions, and drive continuous improvement in infection prevention and control practices.

Standardized Procedures

- Nova Scotia Health Healthcare-Associated Infection Surveillance Manual
 - Standardized case definitions
- [IPC-CD-001 Outbreak Management Policy](#)
- [IPC-RP-001 Routine Practices and Additional Precautions Policy](#) and related policies
- [IPC-CD-030 Reporting Notifiable Diseases and Conditions Policy](#)

Education and Resources

- Outbreak Management Education
- Communication of surveillance findings, trends, and lessons learned
- IPAC consultation and support

Monitoring and Improvement

- HAI surveillance reports and dashboards
- Unit based Reports
- Targeted IPAC interventions
- Quality improvement activities
- Operational Excellence Management System (OEMS)

0.3 Health Care-Associated Infection (HAI) Surveillance

0.3.1 The organizational leaders and teams collaborate to conduct ongoing health care-associated infection surveillance.



0.3.1.1 The organizational leaders maintain a HAI surveillance program.

An organizational HAI surveillance program reflects the type of care provided, the care setting, the populations served.

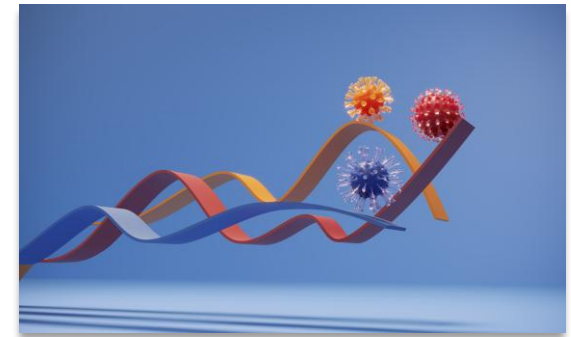
The HAI surveillance program may include:

- identifying HAIs including antimicrobial resistant organisms;
- standardized case definitions;
- data collection and analysis to identify and track clusters, outbreaks, and index cases;
- a digital or paper-based system to capture data;
- a procedure on reporting and responding to HAIs;
- Communication of surveillance findings to key interest holders and public health authorities, as required.



0.3.1.1 Potential Surveyor Questions:

- What do you do if you suspect a patient has an infection? Who do you report it to, and how quickly?
- Do you use any tools, forms, or electronic systems to report infections?
- Can you describe a time you reported a potential infection or concern?
- Are you aware of any trends or issues related to infections on your unit?
- How are infection updates or surveillance findings shared with you?
- What is your role in preventing the spread of infections in your program/facility/area of care?



0.3.1.1 Evidence Examples:

- [Nova Scotia Health's Healthcare Associated Infection Surveillance Manual](#)
- Standardized case definitions available and consistently applied for monitored infections and antimicrobial-resistant organisms
- Team Members can describe how surveillance information is used to prevent and control infections
- Established reporting procedures for key collaborators and public health authorities

HAI Surveillance Case Definitions

HAI Surveillance in Acute Care Settings

Collection of infection data for surveillance purposes must be done using validated, published definitions for HAIs. If the definitions that are used to categorize an infection are not standardized, a health care setting's infection rates cannot be accurately compared to either their own historical infection rates or to external benchmarks.

Case definitions are provided through surveillance programs such as CNISP or through CDC's NHSN or the *Safer Healthcare Now* (now Healthcare Excellence Canada) program. To assist ICPs and other professionals conducting or requesting information on HAIs chosen within the NSH surveillance plan, indicator summary forms have been created. These indicator summary forms include information about the HAI, case definition used in surveillance, how the rate is calculated, the benchmark used to compare rates and any supporting documents related to the HAI.

Source: NS Health HAI Surveillance Manual

0.3.1.2, 0.3.1.3 Teams report and respond HAIs as per the organizational procedure

Reporting HAIs may involve :

- reporting HAIs using a digital or paper-based system;
- informing the most appropriate team member;
- reporting HAIs to public health

Teams respond to HAIs, as per the organizational procedure, with infection prevention and control measures, such as:

- use of personal protective equipment;
- isolation and other precautions;
- cohorting strategies;
- environmental cleaning;
- waste handling;
- return-to-work policies;
- adhering to pre-emptive testing requirements such as point prevalence testing; and
- adhering to prophylaxis protocols.

It's The Law Reporting Notifiable Diseases and Conditions

The Health Protection Act (novascotia.ca/dhwr/cdpc/acts-and-legislation.asp) requires that the diseases and conditions listed below be reported to Nova Scotia Health, Public Health.

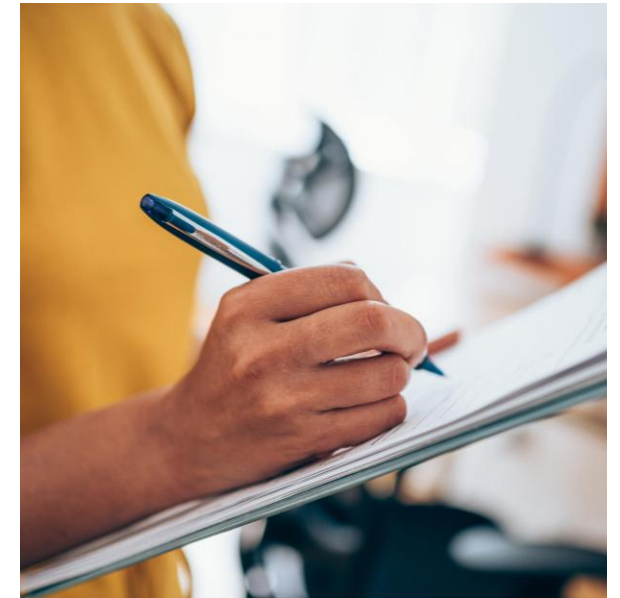
For more information on case definitions for notifiable diseases in Nova Scotia, please refer to the Surveillance Guidelines: novascotia.ca/dhwr/populationhealth/diseases-and-conditions-4-2.asp.

Report as soon as SUSPECTED by telephone		
All unusual disease clusters, disease outbreaks, and unusual disease occurrences should be reported immediately.		
• Acute Flaccid Paralysis (AFP) • Anthrax • Botulism • Cholera • Diphtheria • Ebola Disease • Group A Streptococcal Disease Invasive • Haemophilus Influenzae Type B Invasive Disease (HIB) • Hepatitis A	• Influenza: Highly Pathogenic Avian Influenza (HPAI) • Measles • Meningococcal Disease Invasive • Mpox • Plague • Poliomyelitis • Rabies • Rubella (including Congenital Rubella Syndrome) • Severe Acute Respiratory Infection (SARI)	• Severe Acute Respiratory Syndrome (SARS) • Shellfish Poisoning (Paralytic and Amnesic) • Smallpox • Tuberculosis • Typhoid • Shiga toxin-producing E. coli • Viral Hemorrhagic Fevers (Crimean-Congo, Lassa, Marburg, Rift Valley)

Report by next business day

0.3.1.2, 0.3.1.3 Potential Surveyor Questions:

- How do you report a HAI?
- Who should be notified when a HAI is identified?
- What happens after an HAI is reported?
- What environmental cleaning requirements are followed when a health care-associated infection is identified?
- Can you describe outbreak response procedures?
- How do you know when additional precautions or other IPC measures are required?



0.3.1.2, 0.3.1.3 Evidence Examples:

- Team Members can explain how and when to report suspected or confirmed infections
- Defined notification process identifying who must be informed (e.g., IPAC, leadership, occupational health, public health)
- Evidence of timely reporting to public health authorities when required
- Signage and Additional Precautions in place, where indicated
- Team Members can describe appropriate infection prevention and control measures

	CONTACT	CONTACT +	ENHANCED CONTACT	DROPLET	DROPLET & CONTACT	DROPLET & ENHANCED CONTACT	AIRBORNE	AIRBORNE & CONTACT
Disease or Microorganism Examples (suspected or confirmed)	MRSA Scabies Draining Wounds	<i>C. difficile</i> <i>C. auris</i> Norovirus Rotavirus	CPE VRE	Mumps Pertussis Rubella	Influenza/RSV Meningitis/IGAS Nec. fasciitis Covid-19 Add Airborne for Covid-19 AGMP	CPE sputum CPE/VRE and: • VRIs • Meningitis • IGAS • Nec. fasciitis	TB Measles	Chicken Pox Disseminated Shingles
Hand Hygiene	✓	Soap/Water	✓	✓	✓	✓	✓	✓
Negative Pressure Room	No	No	No	No	No	No	✓	✓
Mask/N95 Respirator	PCRA	PCRA	PCRA	Medical Mask	Medical Mask	Medical Mask	N95	N95
Gown & Gloves	✓	✓	✓	PCRA	✓	✓	PCRA	✓
Eye/Face PPE	PCRA	PCRA	PCRA	✓	✓	✓	PCRA	PCRA
Transport pt. in medical mask	PCRA	PCRA	PCRA	✓	✓	✓	✓	✓
Notify Depts. on transfer	✓	✓	✓	✓	✓	✓	✓	✓
Daily/Discharge Clean	✓	2x Daily "Sporicidal"	2x Daily "Scrubbing"	✓	✓	2x Daily "Scrubbing"	✓	✓
Privacy Curtains	Change	Change	Change	Change	Change	Change	Change	Change

Clinical Findings	Potential Pathogens	Empiric Precautions	Infective Material	Route of Transmission	Duration of Precautions	Comments
Abscess (see draining wound)						
Bronchiolitis	Respiratory syncytial virus (RSV), human metapneumovirus, parainfluenza virus, influenza, adenovirus	Droplet & Contact Precautions	Respiratory secretions	Large droplet & direct and indirect contact	Duration of symptoms	Patient should not share room with high-risk roommates.
Burns, infected (see draining wound)						
Cellulitis Draining (see draining wound)	<i>Haemophilus influenzae</i> type B in non-immune child <2 years of age; <i>Streptococcus pneumoniae</i> , group A <i>Streptococcus</i> , <i>Staphylococcus aureus</i> , other bacteria	Droplet Precautions if <i>H. influenzae</i> type B is possible cause, otherwise Routine Practices	Respiratory secretions	Large droplet, direct contact	Continue until 24 hours of appropriate antimicrobial therapy received or if <i>H. influenzae</i> type B ruled out	
Periorbital in child <5 years old without portal of entry						
Cold	Rhinovirus, RSV, human metapneumovirus, parainfluenza, adenovirus, coronavirus	Droplet & Contact Precautions	Respiratory secretions	Large droplet & direct and indirect contact	Duration of symptoms	Patient should not share room with high-risk roommates.
Conjunctivitis	Adenovirus, enterovirus, chlamydia, <i>Neisseria gonorrhoea</i>	Contact Precautions*	Eye discharge	Direct and indirect contact	Until viral etiology ruled out; duration of symptoms, up to 14 days if viral	*Routine Practices if non-viral.
Fever, fever, acute onset	Rhinovirus, RSV, human metapneumovirus, parainfluenza,	Droplet & Contact	Respiratory	Large droplet,	Duration of symptoms or until	Consider fever and asthma in child <2 years old as viral infection.

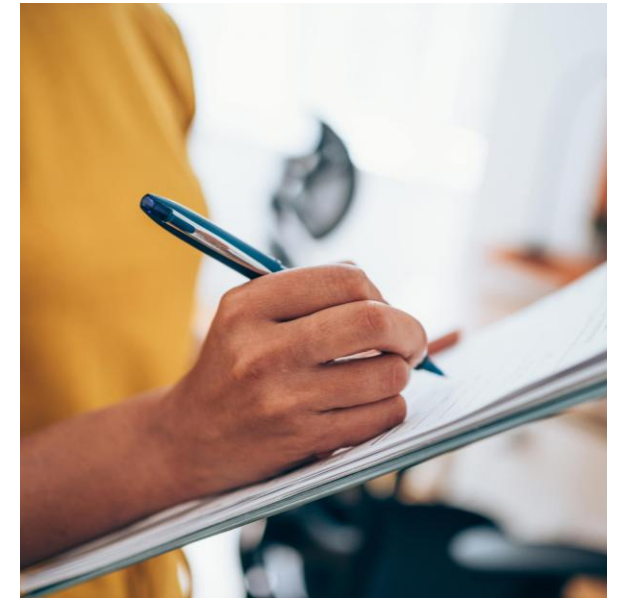
0.3.1.4, 0.3.1.5 Teams collect and analyze data on HAIs and communicate information on the outcomes as per the organizational HAI surveillance program

Teams:

- Identify and track HAIs, clusters, outbreaks, and index cases
- Collect data through passive reporting and active surveillance methods
- Analyze trends, sources, and patterns of transmission
- Use findings to recommend IPAC interventions and prevent recurrence
- Communicate results to stakeholders and public health authorities as required

0.3.1.4, 0.3.1.5 Potential Surveyor Questions:

- How would you recognize a potential infection?
- Who would you notify if you identified an infection concern?
- How are HAIs reported in your area?
- What happens when an HAI is identified?
- Can you describe outbreak response procedures?
- How are surveillance findings shared with staff?
- Can you describe a time when infection surveillance led to a change in practice on your unit?



0.3.1.4, 0.3.1.5 Evidence Examples:

- Team Members can describe how to identify and report suspected health care-associated infections
- Team Members can explain how infection surveillance information is communicated in their area
- Unit huddle boards, dashboards, newsletters, emails, or communication boards displaying infection prevention and surveillance information
- Team Members can describe IPAC measures implemented in response to surveillance findings
- Team Members awareness of current outbreaks, infection trends, or organism-specific concerns relevant to their area

0.3.1.6 The organizational leaders implement infection prevention and control measures based on outcomes from the health care associated infection surveillance program

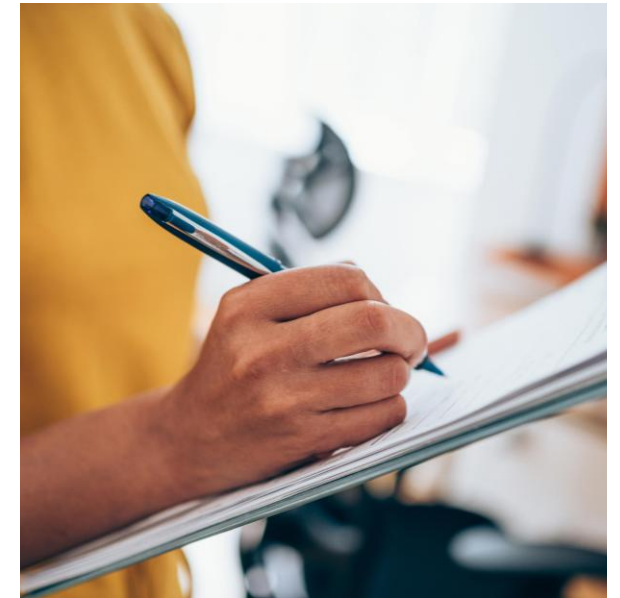
Timely IPAC measures may help minimize risk, transmission, and prevent recurrence.

Implementing IPAC measures may involve:

- personal protective equipment protocols;
- enhanced cleaning and disinfection measures;
- visitor restrictions;
- pre-emptive testing requirements, such as point prevalence testing;
- prophylaxis protocols; and
- updated IPAC policies

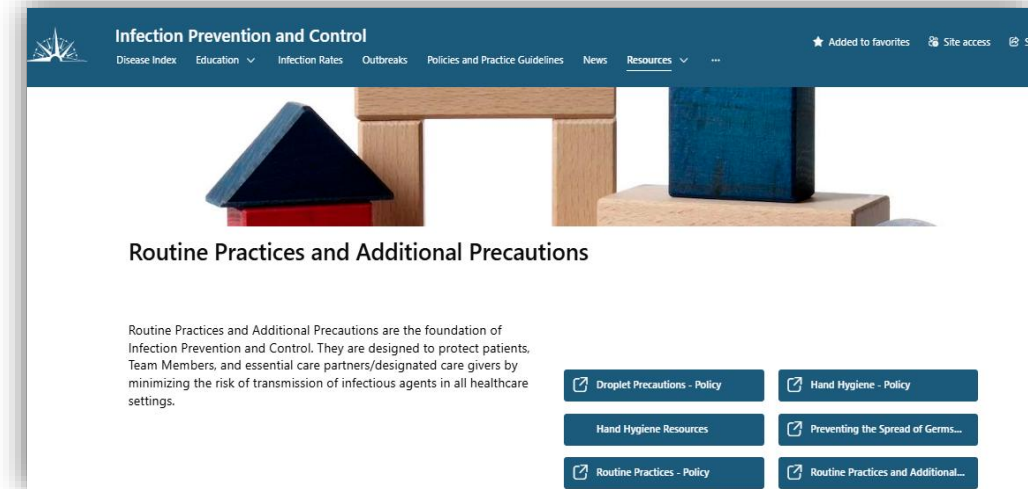
0.3.1.6 Potential Surveyor Questions:

- Can you describe a time when infection surveillance led to a change in practice on your unit?
- How are you informed when there is an increase in infections, an outbreak, or a new infection prevention and control measure?
- Can you provide an example of Additional Precautions that were recently introduced in your area?
- An outbreak has been declared on your unit. What actions would you expect to take?
- How do you know what PPE is required for a particular infection or outbreak situation?



0.3.1.6 Evidence Examples:

- Team Members can describe IPAC measures implemented as a result of surveillance findings.
- Team Members demonstrate knowledge of current outbreak management or enhanced IPAC practices relevant to their area.
- Use of appropriate PPE
- Meeting minutes, outbreak records, or action plans linking surveillance findings to implemented interventions
- Team Members can identify where to find current guidance and who to contact with infection prevention and control concerns.



Outbreaks

Early identification, investigation and control measures are critical to contain and curtail an outbreak. To ensure early detection and prompt management, outbreaks occurring within Nova Scotia Health facilities are managed collaboratively involving the active participation of various individuals and stakeholders. Outbreaks are reportable to local Public Health services as per ["It's the Law: Reporting Notifiable Diseases and Conditions"](#).

Infection Prevention and Control maintains an updated list of outbreaks, available Monday to Friday from 8am to 4pm, excluding holidays.

▼				
▼	Date Declared ↓	Type of Outbreak	Facility	Unit
▼	Zone: Central (1)			

0.3.1.7 The organizational leaders provide teams with access to continuous learning activities on health care-associated infection surveillance.

Continuous learning helps teams, including clients and their designated support persons, improve HAI surveillance.

Learning topics may include:

- identifying health care-associated infections and understanding how they are transmitted;
- prevention strategies, such as proper use of PPE, hand hygiene, and cleaning and disinfecting medical equipment, devices, and the physical environment;
- reporting, documenting, and responding to HAIs as per the surveillance program; and
- how the organizational leaders are demonstrating continuous improvement in HAI surveillance as evidenced by outcomes

Providing learning activities in various ways may help engage team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, published articles, client safety reports, reflective practice, and mentorship initiatives.

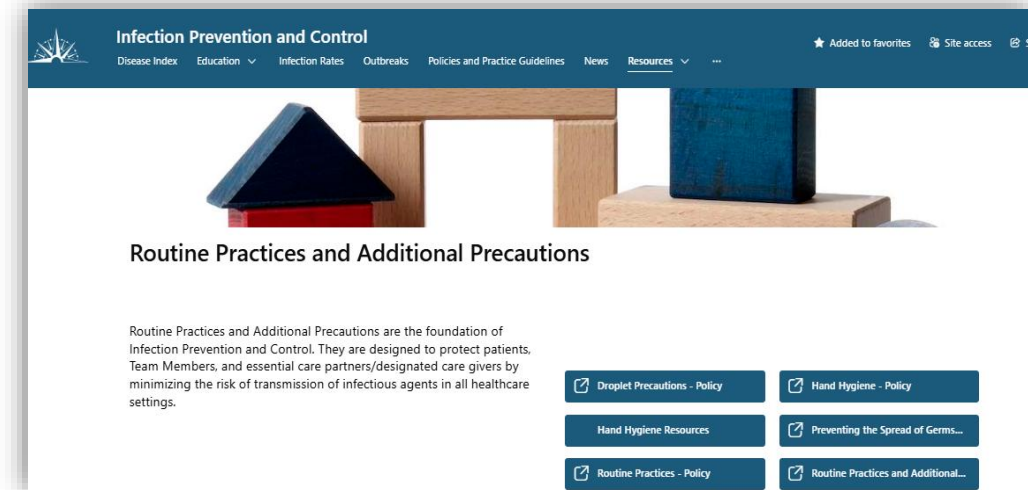
0.3.1.7 Potential Surveyor Questions:

- What education have you received on HAIs?
- How do you recognize a potential HAI?
- How have you been educated on hand hygiene, PPE, and Additional Precautions?
- What would you do if you identified a potential infection control risk?
- Can you provide an example of IPAC learning you've completed in the last year?



0.3.1.7 Evidence Examples:

- Education and training program on HAI surveillance and prevention
- Records of education completion, attendance, competency assessments, or learning participation.
- Team Members demonstrate appropriate IPAC practices when observed
- Communication materials sharing surveillance results, outbreak information, infection trends, and lessons learned
- Educational content reflects current evidence-based practices, organizational requirements, and emerging infection risks



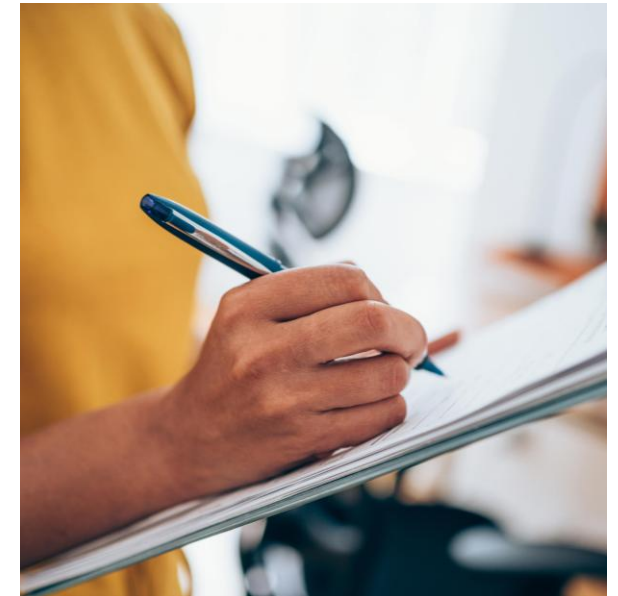
0.3.1.8, 0.3.1.9, 0.3.1.10 Teams measure and monitor the effectiveness of the HAI surveillance program, benchmark results to identify improvement opportunities, and demonstrate continuous improvement through measurable outcomes.

Teams:

- Monitor HAI rates, IPAC compliance, response outcomes, safety data, and stakeholder feedback
- Use dashboards, reporting systems, and observations to evaluate program effectiveness
- Benchmark results against internal performance, organizational trends, and external comparators
- Identify opportunities to improve surveillance processes and IPC practices
- Implement and sustain improvements based on findings and lessons learned
- Demonstrate measurable improvements in quality, safety, and HAI surveillance outcomes

0.3.1.8, 0.3.1.9, 0.3.1.10 Potential Surveyor Questions:

- Are surveillance results or infection trends shared with staff? How?
- Can you provide an example of an improvement that was implemented to reduce infection risk?
- How do you provide feedback about infection prevention and control concerns?
- How are you informed about lessons learned from outbreaks or infection events?
- What reports related to infection prevention do you see in your area?
- How do your results compare to internal targets or external comparators?
- If surveillance data shows an increase in infections over the last quarter, what happens next?



0.3.1.8, 0.3.1.9, 0.3.1.10 Evidence Examples:

- Dashboards, scorecards, and performance reports available to teams and leaders.
- Evidence that surveillance findings are reviewed regularly by operational, quality, and IPAC teams.
- Quality improvement initiatives linked to surveillance findings.
- Action plans developed when adverse trends, outbreaks, or increased infection rates are identified.
- Team Members can describe how surveillance findings have led to safer care and improved infection prevention practices.

Table 1: Comparison against Target for Provincial-level Indicators Required Under the Patient Safety Act

Patient Safety Act	Target	2025/26			
		Q1	Q2	Q3	Q4
Hand Hygiene (higher is better – aim to be at or above target)					
Compliance rate before patient contact (Moment 1) was relatively stable over the fourth quarter, nearing target	80%	74.4%	78.8%	77.6%	78.5%
Compliance rate after patient contact (Moment 4) continues to exceed target	80%	88.1%	90.0%	89.0%	89.3%
Healthcare-associated Infections Acquired at an Acute Care Facility (lower is better – aim to be at or below target)					
Number of <i>Clostridioides difficile</i> infections (CDI) per 10,000 patient days continues to be below target	5.02	3.06	2.52	3.28	3.22
Number of Methicillin-resistant <i>Staphylococcus aureus</i> bloodstream infections (MRSA BSI) per 10,000 patient days continues to be below target	1.01	0.18	0.26	0.09	0.08
Number of central line-associated bloodstream infections (CLABSI) per 1,000 central line days in an adult* ICU was below target	1.93	1.98	1.53	1.57	1.91

IPAC Tools and Resources

- **IPAC Policies**

- [IPC-RP-001 Routine Practices and Additional Precautions Policy](#)
- [IPC-RP-005 Routine Practices](#)
- [IPC-RP-010 Contact Precautions](#)
- [IPC-RP-015 Droplet Precautions](#)
- [IPC-RP-025 Airborne Precautions](#)
- [IPC-RP-020 Hand Hygiene](#)
- [IPAC Compass Routine Practices and Additional Precautions Page](#)
- [IPC-CD-001 Outbreak Management Policy](#)

- **IPAC Compass**

- [Routine Practices and Additional Precautions Page](#)
- [Organism-Specific Guidance](#)
- [Safety Huddles](#)
- IPAC Campaigns
 - *Clean and Safe*
 - *Scoop on Poop*
- [IPAC Newsletters](#)
- [IPAC LMS Courses](#)



Cleaning and Low-Level Disinfection (LLD) of Medical Equipment

Required Safety Practice

Cleaning and LLD of Medical Equipment

- Reusable non-critical medical equipment moves between patients, clients, and care environments every day (e.g. vital signs monitor) .
- When equipment is not cleaned and disinfected correctly, microorganisms can spread from one person to another and contribute to healthcare-associated infections.
- Consistent cleaning and low-level disinfection reduces the risk of transmission and helps ensure equipment is safe for reuse.

Our Approach



NS Health supports safe cleaning and low-level disinfection through standardized processes, education, monitoring, and continuous improvement.

Standardized Procedures

- IPC-CL-001 Cleaning and Disinfection of Non-Critical Reusable Patient Care Equipment Policy
- Manufacturer Instructions for Use (MIFUs)
- Safety Data Sheets (SDS)

Education and Resources

- LMS education
- Safety huddles
- LLD Toolkit
- IPAC consultation and support

Defined Responsibilities

- Clear assignment of cleaning responsibilities
- Unit-specific responsibility tools
- Expectations for contracted and support services

Monitoring and Improvement

- Audits
- Walk-arounds
- Safety reporting
- Quality improvement activities
- Operational Excellence Management System (OEMS)

Definitions

Cleaning

The removal of foreign and organic material from equipment. Cleaning must occur before disinfection can be effective.

Disinfection

The process of inactivating disease-producing microorganisms by chemical or thermal means

Low-level disinfection

A process capable of killing most vegetative bacteria and some fungi, as well as enveloped viruses. LLD does not kill mycobacteria, non-enveloped viruses, or bacterial spores.

Medical equipment

A non-invasive medical apparatus, appliance, or material **that comes in contact only with a client's intact skin** and is used in the provision of care. Examples include wheelchairs, IV poles, and commodes.

Spaulding Classification

Classification	Definition	Level of Processing/Reprocessing	Examples
Non-critical Equipment/Device	Equipment/device that touches only intact skin and not mucous membranes, or does not directly touch the patient	Cleaning followed by Low Level Disinfection (1 or 2 step)	• Vital Signs Monitor • IV pump • Stethoscope
Semi-critical Equipment/Device	Equipment/device that comes in contact with nonintact skin or mucous membranes but do not penetrate them	Cleaning followed by High-Level Disinfection (as a minimum) Sterilization is preferred	• Respiratory therapy equipment • Ear Syringe tips
Critical Equipment/Device	Equipment/device that enters sterile tissues, including the vascular system	Cleaning followed by Sterilization	• Foot care equipment • Surgical instruments

0.2 Cleaning and Low-Level Disinfection of Medical Equipment

0.2.1 The organizational leaders and teams collaborate to clean and low-level disinfect medical equipment to minimize cross-contamination and mitigate the risk of transmission of health care-associated infections.



0.2.1.1 The organizational leaders maintain a procedure for teams to clean and low-level disinfect medical equipment.

Each type of medical equipment has specific requirements for cleaning and low-level disinfecting between each use, when visibly soiled, and on a regular basis

Teams have access to:

- Policy and procedures,
- Safety data sheets,
- Manufacturer's Instructions for Use (MIFU)

Cleaning and LLD procedures may include:

- Clearly defined roles and responsibilities for teams, including contracted teams
- Cleaning and LLD frequency requirements
- Instructions for complex medical equipment, including disassembly and reassembly
- Processes for identifying, handling, transporting, and storing clean/soiled medical equipment
- Storage, preparation, and safety precautions for cleaning and low level disinfecting medical equipment
- Compliance and evaluation methods such as visual observation

		Policy & Procedure	
Policy Title:		Cleaning and Disinfection of Non-Critical Reusable Patient Care Equipment	
Applies To:		All Team Members working in clinical areas	
Approved:	Effective:	Next Review:	
Feb. 22, 2022	Feb. 22, 2022	Feb. 22, 2026	
Sponsor:		Senior Director, Quality Improvement, Safety and Patient Relations	
Approval Authority:		VP, Quality and System Performance Executive Leadership Team	
Number:	IPC-CL-001	Manual:	Infection Prevention and Control
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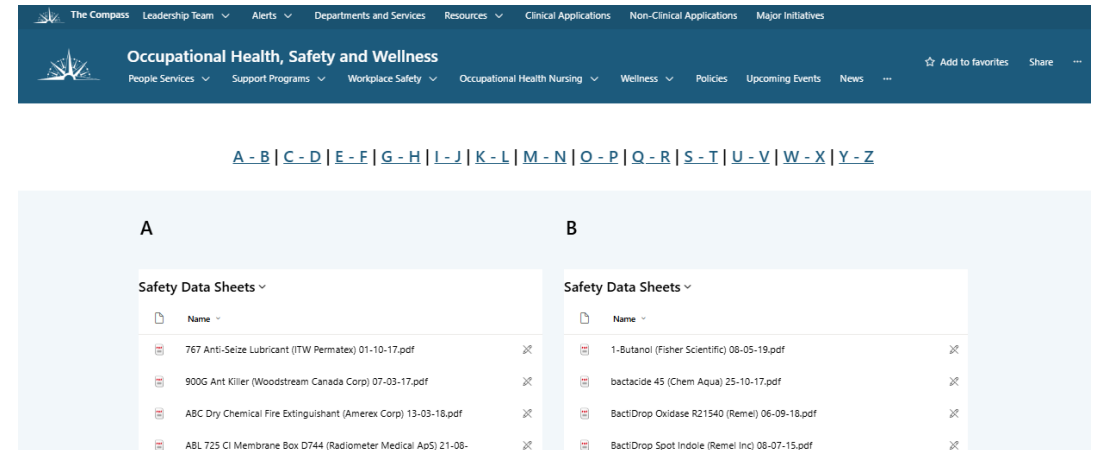
0.2.1.1 Potential Surveyor Questions:

- Can you describe the steps you follow to clean and LLD this piece of equipment?
- Where can you access NSH's procedure and the MIFU at the point of use?
- How often do you clean this piece of equipment?
- What steps do you take to identify, handle, and store equipment that needs to be cleaned, versus equipment that has been cleaned and ready to reuse?



0.2.1.1 Evidence Examples:

- Cleaning and LLD procedure available at point of use, including roles, frequency, and instructions for complex equipment.
- MIFUs and SDS for chemicals and equipment posted or easily accessible.
- Observation of staff following correct steps; staff can locate and explain procedure.
- Designated cleaning areas, proper PPE, labeled chemicals, and correct storage for clean vs. soiled equipment.
- Records of audits, competency checks, and corrective actions.



0.2.1.2 Teams use proper cleaning and low-level disinfection equipment and supplies in an appropriate area, as per the organizational procedure.

- Equipment and supplies include chemical agents, dilution and concentration testing materials, and personal protective equipment.
- Using cleaning and LLD equipment and supplies in an appropriate area, as per the organizational procedure, may also involve:
 - additional required precautions;
 - appropriate storage of equipment and supplies; and
 - safe transport and disposal of equipment and supplies



0.2.1.2 Potential Surveyor Questions:

- How do you verify the correct dilution/concentration?
- Can you show me where this equipment is cleaned and low-level disinfected and how is this area designated and separated from clean/storage areas (e.g., dirty/clean zones, splash protection)?



0.2.1.2 Evidence Examples:

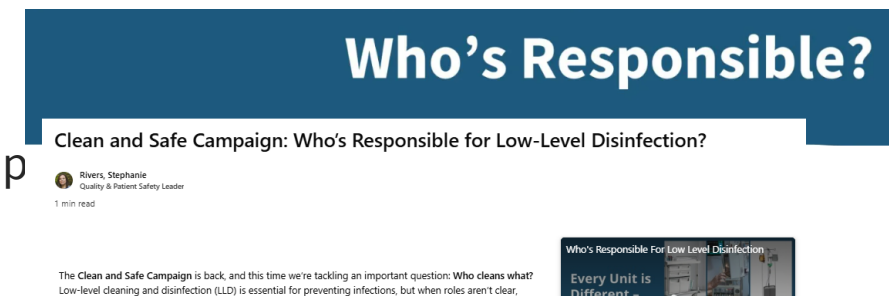
- Clearly identified space for cleaning and LLD, separated from clean storage areas
- Appropriate precautions in place (e.g., splash protection, ventilation)
- Approved disinfectants and cleaning agents available, labeled, and within expiry
- PPE (gloves, gowns, eye protection) accessible and used correctly
- Dilution/concentration testing materials present and logs maintained
- Chemicals stored according to manufacturer instructions and WHMIS requirements
- Safe transport of chemicals and equipment between areas
- Disposal of used wipes/solutions documented and compliant with regulations
- Records of area checks, supply replenishment, and compliance audits
- Evidence of staff training on safe use and handling of chemicals

0.2.1.3 The organizational leaders provide teams with access to continuous learning activities on cleaning and low-level disinfection of medical equipment.

Topics may include:

- Importance of cleaning and LLD
- WHMIS and GHS requirements
- Product selection and use
- Incident reporting;
- Proper storage of clean medical equipment
- Continuous improvement initiatives

Education may be provided through a variety of approaches, including in-person or virtual training and simulation sessions, awareness campaigns, published articles, client safety reports, reflective practice, and mentorship initiatives



0.2.1.3 Potential Surveyor Questions:

- How do you ensure staff complete LLD training during orientation and when procedures or products change?
- What topics are covered in training (e.g., safety, WHMIS, correct chemical use), and how is training delivered to meet different learning needs?
- How do staff provide feedback on LLD learning activities, and can you share an example of a change made based on that feedback?



0.2.1.3 Evidence Examples:

- Attendance logs for orientation, refreshers, and updates when products or procedures change.
- Documentation for students, clients, and staff completing required training before providing care.
- Materials covering key topics: importance of LLD, WHMIS/GHS, correct chemical use, and incident reporting.
- Evidence of multimodal delivery (e.g., in-person, virtual, simulation, campaigns).
- Post-training evaluations or quizzes.
- Documentation showing staff feedback on learning activities and examples of changes made based on that feedback.
- Policies or schedules showing staff are given time to participate in learning sessions – confirmed by staff

Name

Cleaning and Disinfection of Non-Critical Reuseable Patient Care



The cleaning and disinfection of reusable, non-critical patient care equipment is a crucial part of patient safety and an Accreditation Canada Required Organizational Practice.

This course introduces learners to the essential knowledge, procedures and products required to properly clean and disinfect reusable, non-critical patient care equipment.

In this course, learners will:

- Review the Spaulding Classification system
- Explore the importance of the cleaning and disinfection of this equipment
- Understand the requirements of a patient equipment cleaning and disinfection procedure
- Recognize their role and responsibility in the equipment cleaning and disinfection process

Safety Huddle – Cleaning and Disin...

	Title
	Choosing the Right Disinfectant
	Cleaning and Disinfection Safety Huddle
	Clean vs Soiled Equipment Huddle
	Clear Space = Safe Space Huddle
	Clear the Clutter Safety Huddle
	Hands First Wows Second Safety Huddle
	Sharing Isn't Always Caring Safety Huddle

0.2.1.4 Teams measure and monitor the effectiveness of cleaning and low-level disinfecting medical equipment

LLD of medical equipment may be measured and monitored through:

- observational activities and audits to assess team adherence to the procedure, such as walk arounds to ensure proper identification and storage of clean and soiled medical equipment;
- safety and harm data; and
- team member, client, and family feedback

Low-Level Disinfection Equipment Monitoring Tool

This tool is used to monitor and document the proper cleaning and low-level disinfection (LLD) of shared equipment.

Facility: _____ Unit/Department: _____

Date: _____ Shift (circle): Day Evening Night

Completed by: _____

Time	Equipment Name/ID	Disinfectant Used	Contact Time Met (Y/N)	Initials

0.2.1.4 Potential Surveyor Questions:

- What specific aims and measures are being tracked for LLD (e.g., adherence %, defects found on validation), and how do results inform updates to the procedure?
- How are clients or designated support persons encouraged to share concerns or feedback about equipment cleanliness, and how is that feedback acted upon?



0.2.1.4 Evidence Examples:

- Records of staff involvement in audits, walk-arounds, and incident reviews.
- Evidence of staff feedback collected (surveys, huddles) and changes made based on that feedback.
- Logs of targeted education sessions following identified gaps or incidents.
- Audit results linked to improvement actions.



0.2.1.5 The organizational leaders demonstrate continuous improvement in the cleaning and low-level disinfection of medical equipment to minimize cross-contamination and mitigate the risk of transmission of health care-associated infections.

- Continuous improvement is the ongoing process of identifying, implementing, and sustaining incremental changes to improve the cleaning and low-level disinfection of medical equipment.
- Improvements may be focused on implementing new approaches, streamlining processes, or reducing risk and harm.
- Continuous improvement also involves maintaining the procedure and continuous learning activities over time to support alignment with evidence-informed practices, jurisdictional requirements, and learnings from safety and harm data.
- Sharing improvements and learning through established networks, communities of practice, publications, and conferences can further the spread and scale of improving the cleaning and low-level disinfection of medical equipment.

0.2.1.5 Potential Surveyor Questions:

- What QI activities have you personally taken part in over the past quarter related to cleaning and LLD?
- After a safety incident or near miss, how are learnings shared with your team and incorporated into practice (e.g., RCA outcomes, PDSA cycles)?



0.2.1.5 Evidence Examples:

- Examples of revised procedures or workflows based on team participation
- Meeting minutes or action plans showing team input on procedure updates.



Operational Excellence Management System

- Ongoing review of Team Member education and training
- Number of reported issues or safety concerns related to equipment cleaning and disinfection
- Unit based audits using IPAC checklists
- Safety Huddles focused on Improving LLD Practices

Unit Manager Environment Checklist



The purpose of this checklist is to allow unit managers to complete a quick check of their unit's environment to ensure compliance with infection prevention and control standards. This list covers key areas for maintaining the environment.

General

- ☐ All areas, including corridors, are tidy and free of clutter
- ☐ Floors, walls, and ceilings are clean, intact, and in good repair
- ☐ No food or drink at workstations or nursing desks
- ☐ Furnishings are in good repair, non-porous, and able to be cleaned and disinfected with hospital's cleaner/disinfectant. No fabric furniture.
- ☐ Covering on mattresses and pillows are intact without rips/cracks
- ☐ Hand hygiene and infection rates are posted
- ☐ Alcohol Based Hand Rub (ABHR) is mounted at all entrances/ exits and near workstation on wheels
- ☐ Shared equipment is cleaned and disinfected between uses (e.g. blood pressure cuffs, stethoscopes, etc.)
- ☐ Clean laundry is stored in covered carts
- ☐ Charts are stored in cleanable racks/cupboards and disinfected regularly (scheduled)

Medication Room

- ☐ The medication area and equipment have a clean, orderly appearance
- ☐ Countertops and surfaces are non-porous, cleanable, and intact (no cracks or chips)
- ☐ Alcohol based hand rub (ABHR) and Hand hygiene sink and supplies (soap and paper towel) are available
- ☐ Sinks close to medication preparation area have a splash guard and no items stored in or around the "splash zone" (within 1m/3 feet of the sink)

Available IPAC Tools and Resources

- Infection Control Practitioners
- [IPC-CL-001 Cleaning and Disinfection of Non-Critical Reusable Patient Care Equipment](#)
- [Low level Cleaning and Disinfection Toolkit](#)
- [Cleaning and Low-Level Disinfection Responsibility Tool](#) & [Template](#)
- [Safety Huddles](#)
 - *Choosing the Right Disinfectant*
 - *Clean vs Soiled Equipment*
 - *Clear the Clutter*
 - *...and more!*
- LMS course: Cleaning and Disinfection of Non-critical Reusable Patient Care Equipment (Course #101)
- Additional Tools can be found on IPAC Environmental Cleaning Page:
 - *Clutter Resources*
 - *Choosing the Right Disinfection Product Guidance*
 - *Clean vs. Soiled Quiz*
 - *Clinical Storage Checklist*
 - *Unit Manager Checklist*
 - *Smart Storage= Safe Storage Checklist*
 - *Spot the Storage Trouble*
 - *Quick Reference Guide for Cleaning Informatics Equipment*

Cleaning and Low-Level Disinfection

EZ MHA RSP Preparation Working Group

EZ MHA

May 15 – June 12, 2026

Working Group Members: Sheri Cunningham, Angela Stewart, Cora MacAulay, Terry Boudreau, Denise McDonnell, Sean Macisaac, Andrea Blois, Ashley Surette, Dawn Van Den Heuvel, Val Crowdis (PFA) Joshua Spooner, Craig Watson, Lynn Boutilier, Mary Musgrave, Stephanie Rivers, Lori Butts, Chera Clements, Corinna Simon, Alicia MacLeod, Bhreagh Boone

Purpose:

- to discuss highlights from the affiliated policies shared at previous meeting
- to review and discuss the support document for LLC Equipment
- to review the equipment identified at the various sites
- to discuss the process(es) for handling equipment once cleaning and low-level disinfection occurs
- to discuss possible auditing processes at the various sites
- to review and discuss IPAC Reference Materials for Cleaning and Low-Level Disinfection of Medical Equipment
- to review use of provided Safety Huddles

Others to be included in this working group:

- Potential discussions with EVS staff at the appropriate sites

Any other considerations:

- TBD

Frequency of Meetings

- 3-4 times plus a few other interim points for touching base for clarification and input

1) Items for the working group to consider for evidence for this standard section:

- ✓ Types of Multiple-Use Medical Equipment we handle at our sites
- ✓ Specific requirements for cleaning and disinfecting each piece of equipment
- ✓ Instruction for cleaning and disinfecting
- ✓ Responsibility for cleaning and disinfecting
- ✓ Timing of cleaning and disinfecting

2) Items for the working group to consider for evidence for this standard section:

- ✓ Types of cleaning and disinfecting supplies we have and/or need at our sites
- ✓ MSDS specifications for each cleaning and disinfecting product
- ✓ Routine cleaning by staff with Environmental Services
- ✓ Where to clean and disinfect the equipment
- ✓ How and where to safely store the cleaning and disinfecting supplies
- ✓ How to safely store the cleaned and disinfected medical equipment between each use
- ✓ How to safely transport cleaning and disinfecting products and equipment
- ✓ How to safely transport broken/expired medical equipment that we have been cleaning and disinfecting

3) Items to consider for evidence for this standard section:

- ✓ WHIMS Training Annually on LMS
- ✓ SIMS Report review specific to cleaning and disinfecting issues
- ✓ New staff training
- ✓ Refresher boosters

4) Items to consider for evidence for this standard section:

- ✓ Auditing
- ✓ Walk arounds
- ✓ Safety Huddle Reminders and discussions (part of regular board discussions)
- ✓ Tracking Template for evidence
- ✓ Clean/Not-Cleaned stickers/signage

5) Items to consider for evidence for this standard section:

- ✓ Seek and review resources for medical equipment cleaning and low-level disinfecting
- ✓ Advocate for consistency amongst staff/team members

IPAC Reference Materials for this RSP

Compass - Department and Services – Infection Prevention and Control - Policies and Practice Guidelines

- [Routine Practices and Additional Precautions](#)
- [Routine Practices](#)
- [Cleaning and Disinfection of Non-Critical Reusable Patient Care Equipment](#)
- [Cleaning and Disinfection of the Environment and Devices for Primary Care Practices](#)

Safety Huddles

- [Who's Responsible Safety Huddle](#)

IPAC Reference Materials for Cleaning and Low-Level Disinfection of Medical Equipment



[Unit-manager-checklist](#)



[LLD-Toolkit](#)



[News](#)



[Inpatient-Unit-Decluttering-Tool](#)



[LLD-Responsibility-Tool](#)



[LLD-Responsibility-Tool-Template.docx](#)

Infection Prevention and Control

Cleaning and Low-Level Disinfection Responsibility Tool

Modified for Eastern Zone Mental Health and Addiction Services

Maintaining a clean and safe environment is essential to preventing the spread of infection. This tool is designed to support teams in identifying responsibilities related to cleaning and low-level disinfection of equipment used in patient care and clinical settings.

This document lists examples of equipment that require cleaning and low-level disinfection within our EZ MHA facilities. For each item, please find:

- A picture resembling the equipment requiring this level of cleaning and disinfection.
- The most appropriate staff member role(s) responsible for cleaning the item.
- The location where the equipment is typically cleaned.
- When and how often cleaning and low-level disinfection should take place and if there are any special packaging instructions following this process.
- The current suggested product used for cleaning and disinfecting; and
- The length of time the item needs to remain wet with the product to be disinfected.

Please note:

- Equipment listed is not inclusive and practices may vary from unit to unit. Each site/unit is to verify the person/position responsible and the appropriate product to be used for cleaning and low-level disinfection of equipment used in patient care and clinical settings.
- Staff must **ALWAYS** store cleaning and disinfecting products away from Dirty Products and dust and direct airflow (i.e., not under a ventilation system).
- Product efficacy can vary depending on the type of pathogen. Not all disinfectants are effective against all microorganisms. Staff must **ALWAYS** refer to the [product label](#), [Safety Data Sheet \(SDS\)](#), and [Manufacturer's Instructions for Use \(MIFU\)](#) for specific precautions to use while cleaning and disinfecting the equipment. Contact your local Infection Prevention and Control (IPAC) Practitioner if you have questions or require additional information.
- Bleach is a sporicidal agent that would be used in certain situations, such as someone on Contact plus precautions. Clorox Healthcare Bleach Germicidal Wipes is for sporicidal use. It **must** be used with C diff (Clostridioides difficile) or diarrheal illnesses, but it may be used in other situations.
- Environmental Services and IPAC may substitute with other appropriate and/or superior products, as instructed or as when vendor sources change. All tests for efficacy would be expected to be ensured prior to product use.
- Always check expiry and how to store the product properly.
- Be sure to always read the label and wear the right Personal Protective Equipment (PPE).

Acronyms:

PCU: Point of Care User

EVS: Environmental Services

OT/PT/RT: Occupational Therapist/Physical Therapist/Recreational Therapist

Equipment Name	Cleaned By	Typical Cleaning and Disinfection Location	When to Clean and Disinfect/ Special Packaging Post Processing	Appropriate Cleaning Product(s)	Required Length of Time to Clean and Disinfect	Where to Store Between Uses
Multi-purpose Units for Scanning/ Faxing 	PCU/Unit Clerk	Nursing Station	Daily When soiled Wipe keypads before and after each use Packaging – N/A	Accel PREvention Wipes	3 minutes wet time * Do not towel dry	Nursing Station
	EVS	Point of Use	Clean & disinfect When soiled As required Packaging – N/A	Oxivir Plus/Virex 256 Accel PREvention Wipes	3 minutes wet wipe 3 minutes wet time * Do not towel dry	Nursing Station Administration Offices
Flow meter, oxygen/air 	PCU	Point-of-use Attached to wall port in some areas	When soiled Upon discharge Packaging – N/A	Accel PREvention Wipes Clorox Healthcare Bleach Germicidal Wipes – Note: Sporicidal; must use if suspect C diff or diarrheal illnesses.	3 minutes wet time 10 minutes wet time * Do not towel dry	Bedroom/Storage Room
	PCU	Point-of-use	When soiled After each use Packaging – holder/drawer/storage cabinet	Accel PREvention wipes Clorox Healthcare Bleach Germicidal Wipes – Note: Sporicidal; must use if suspect C diff or diarrheal illnesses.	3 minutes wet time 10 minute wet time * Do not towel dry	Nursing Station
Monitor, central patient  **Not available at all sites	PCU	Nursing Station	Clean & disinfect display/screen, keyboard, mouse When soiled Daily Packaging – N/A	Accel PREvention Wipes	3 minutes wet time * Do not towel dry	Nursing Station
	EVS	Nursing Station	Clean & disinfect Display/screen, keyboard, mouse When soiled As required Packaging – N/A	Oxivir Plus/Virex 256 Accel PREvention Wipes	3 minutes wet wipe 3 minutes wet time * Do not towel dry	Nursing Station
Oxygen Tank 	PCU	Point-of-use	Before each use When soiled Packaging – N/A	Accel PREvention Wipes Clorox Healthcare Bleach Germicidal Wipes – Note: Sporicidal; must use if suspect C diff or diarrheal illnesses.	3 minutes wet time 10 minutes wet time * Do not towel dry	Bedside/Portable at some nursing stations; med room at other sites or storage area

Cleaning and Low-Level Disinfection at MHA in EZ

Manager Go-Live Plan

1. Preparation with Full Team

- ☐ Review Cleaning Reference Manual with all team members and align with Accreditation Canada RSP requirements
- ☐ Recruit volunteer champion(s) for each site
- ☐ Ensure availability of supplies and materials and expectations from whole team
- ☐ Inform team of the need for regular audits and review of results

2. Working with Champions

- ☐ Explain purpose and expectations (to oversee process; perform and report audit checks at regular huddles and/or team meetings)
- ☐ Reinforce key messages using meetings, huddles, email and use of audit tools

3. Champion Support

- ☐ Champions trained appropriately (roll-out process, new hires training, booster sessions/huddles and audits)
- ☐ Provided education materials and resource contacts (i.e., IPPC, Quality Lead)
- ☐ Schedule regular check-ins
- ☐ Develop escalation process with management if staff non-compliance

4. Staff Education

- ☐ Training delivered upon hire and as regularly required
- ☐ Roles and responsibilities covered
- ☐ Cleaning procedures reviewed as appropriate
- ☐ Completion of training tracked (completion expectation is within 30 days of hire date)

5. Implementation

- ☐ Integrate/re-introduce importance of cleaning and low-level disinfection into workflow
- ☐ Cleaning at point of care
- ☐ Visual aids posted

- ☐ Champion available to guide and assist all staff

6. Monitoring & Compliance

- ☐ Audit processes developed and in place
- ☐ Audits completed and reported regularly (monthly)
- ☐ Results Reviewed and any Gaps identified regularly (monthly)
- ☐ Feedback shared with team regularly (monthly)

7. Issue Management

- ☐ Issues identified and Managed with Manager (QL involved as required)
- ☐ Supply problems escalated
- ☐ Training gaps addressed

8. Sustainment

- ☐ Integrated into routine practice
- ☐ Included in orientation
- ☐ Ongoing audits scheduled
- ☐ Champion role maintained/champion replacement as required

9. Success Indicators

- ☐ ≥90% staff trained
- ☐ Audit scores improving
- ☐ Consistent practices observed and lack of compliance addressed through QI processes as needed.

10. Sign-Off

Manager Name: _____

Site: _____

Date: _____

Cleaning and Low-Level Disinfection at MHA in EZ

Champion Plan

1. Preparing front Line Staff

- ☐ Meet with Manager to discuss formal roll out and auditing requirements at site(s)
- ☐ Explain purpose and expectations (to oversee process; perform and report audit checks at regular huddles and/or team meetings)
- ☐ Reinforce key messages using meetings, huddles, email and use of audit tools
- ☐ Discuss Routine Requirements for huddles, audits and reporting results

2. Champion Support

- ☐ Schedule regular check-ins
- ☐ Develop escalation process with management if staff non-compliance

3. Education for New Hires and Ongoing Booster Sessions

- ☐ Training delivered upon hire and as regularly required
- ☐ Roles and responsibilities covered
- ☐ Cleaning procedures reviewed as appropriate
- ☐ Completion of training tracked

4. Auditing

- ☐ Setting a workable audit procedure and timing
- ☐ Audit Cleaning at point of care
- ☐ Audit Storage of Cleaning and Equipment

5. Monitoring & Compliance

- ☐ Audits completed and reported regularly (monthly to begin)
- ☐ Results Reviewed and any Gaps identified regularly (monthly to begin)
- ☐ Feedback shared with team regularly (monthly to begin)

6. Issue Management

- ☐ Issues identified and managed with Manager (QL involved as required)
- ☐ Supply problems escalated

☐ Training gaps addressed

7. Success Indicators

- ☐ ≥90% staff trained – track new hires by date and date trained for LLC – (within 30 days of hire)
- ☐ Audit scores high (≥90%) and/or improving per site
- ☐ Consistent practices observed and lack of compliance addressed through QI processes as needed.

9. Routine Reporting Evidence

Champion Name: _____

Site: _____

Date: _____

Sample Audit Tool

Name of Equipment Audited	Handler's Initials	Did User Clean/Disinfect Before Use	Did User Clean/Disinfect After Use	Equipment Stored Properly Following Use	Patient/Client Observe Process
1.		Y N	Y N	Y N N/A	Y N N/A
2.		Y N	Y N	Y N N/A	Y N N/A
3.		Y N	Y N	Y N N/A	Y N N/A
4.		Y N	Y N	Y N N/A	Y N N/A
5.		Y N	Y N	Y N N/A	Y N N/A
6.		Y N	Y N	Y N N/A	Y N N/A
7.		Y N	Y N	Y N N/A	Y N N/A
8.		Y N	Y N	Y N N/A	Y N N/A
9.		Y N	Y N	Y N N/A	Y N N/A
10.		Y N	Y N	Y N N/A	Y N N/A

Complete each cell within the table by writing the response or circling Y, N or N/A as appropriate.

TOTALS:

___/___ = ___% Clean/Disinfect Before Handling

___/___ = ___% Clean/Disinfect After Handling

___/___ = ___% of Time Equipment Stored Properly Following Use (do not include N/A in count)

___/___ = ___% of Time Patient/Client Observed Cleaning/Disinfection Process (do not include N/A in count)

Final Steps for MHA full RSP Integration:

- Leadership approval
- Manager Sign off Manager Go-Live Plan to ensure understanding
- EZ MHA Champions Meeting
- Team-specific roll out
- Follow-up meetings for audit result review and next steps as needed

Fits with the following EZ MHA Teams:

- Withdrawal Management Units,
- Mental Health Units
- Day Hospital Sites
- Recovery Support Program Sites
- Depot Injection Program Sites

Questions?