

Quarter one (Q1) of 2025/26 (April 1 – June 19, 2025)

Quarterly Surveillance Report

Please read the technical notes at the end of this report for definitions, methodology and considerations for interpretation of results



PICNet wishes to acknowledge with gratitude that we work and live on the traditional, ancestral and unceded territories of many BC First Nations who have cared and nurtured this land for all time.

PICNet's office in Vancouver is located on the traditional land of the x̱m̱əθḵəy̱əm (Musqueam), Skwxwú7mesh (Squamish), and səliwətaʔ (Tsleil-Waututh) Nations.

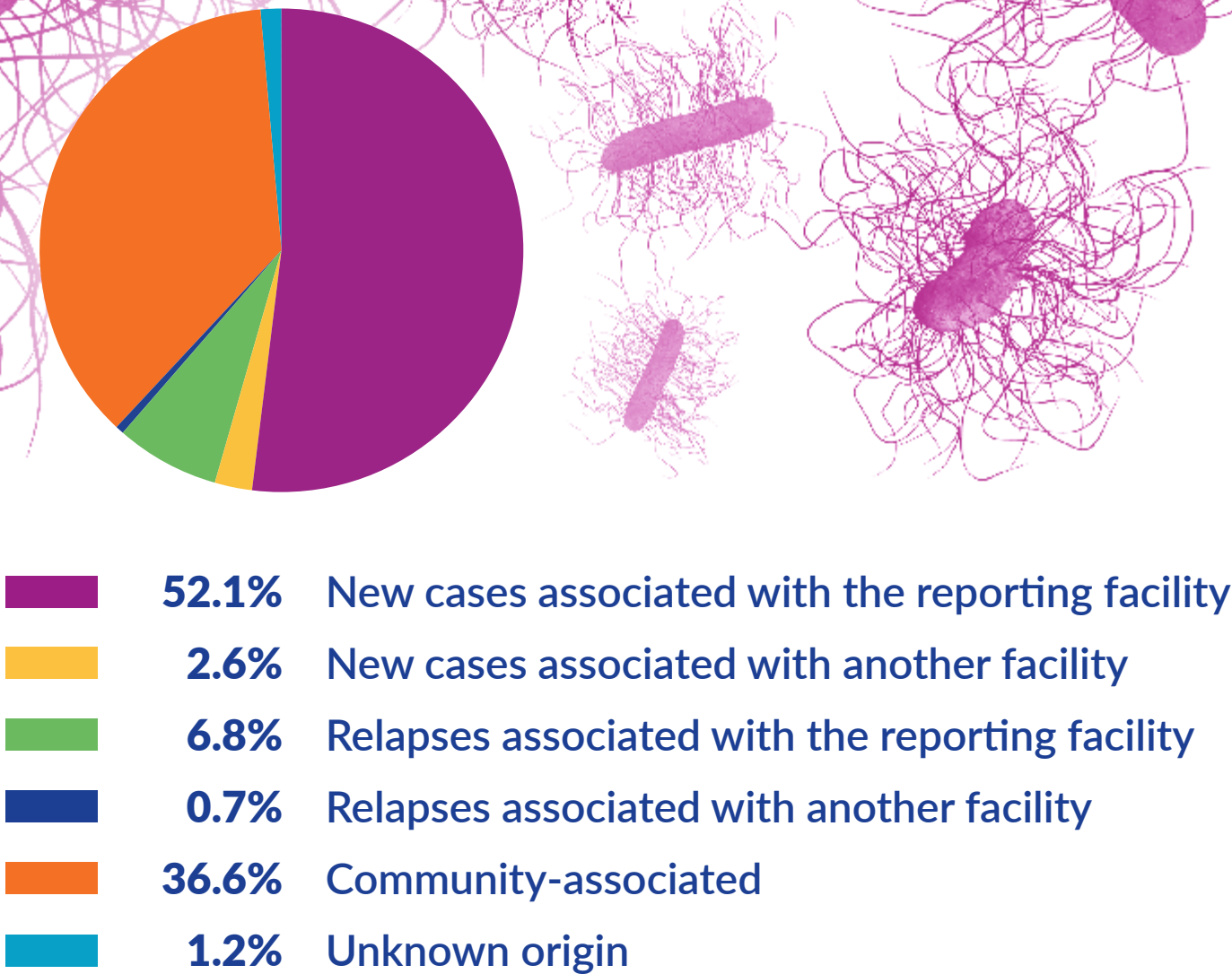
We also acknowledge that there are other Indigenous people that live on these lands that originate from their own respective territories outside of these lands, the Chartered Communities of the Métis Nation BC, and Inuit.

Clostridioides difficile Infection (CDI)

CDI is the most common health care-associated infection. CDI typically causes diarrhea and mostly occurs during or soon after treatment with antibiotics or among people who are immunocompromised.

New cases and relapses identified among inpatients in acute care facilities are under provincial surveillance.

Distribution (%) of CDI episodes reported in acute care facilities by classification, Q1 of 2025/26 (n = 426)



HIGHLIGHTS

2.9 per 10,000 inpatient days

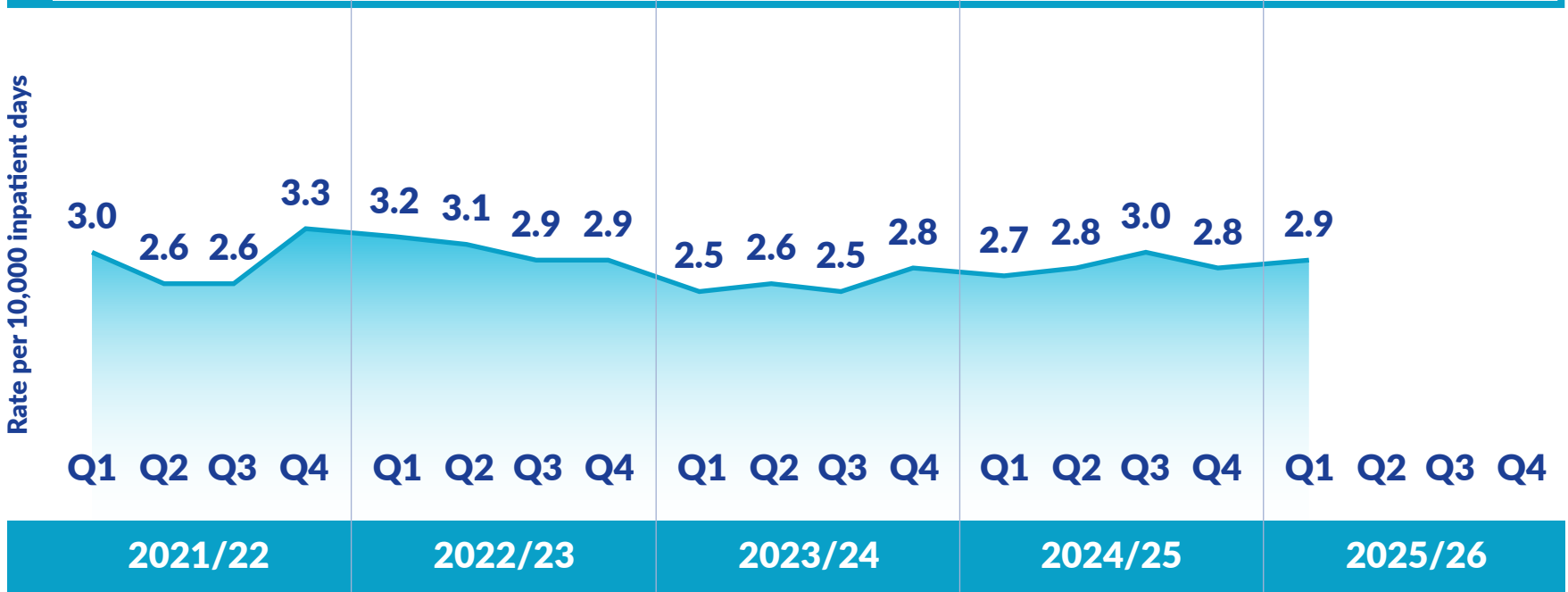
Quarterly provincial rate of new CDI cases associated with the reporting facility

Provincial rates of CDI have increased

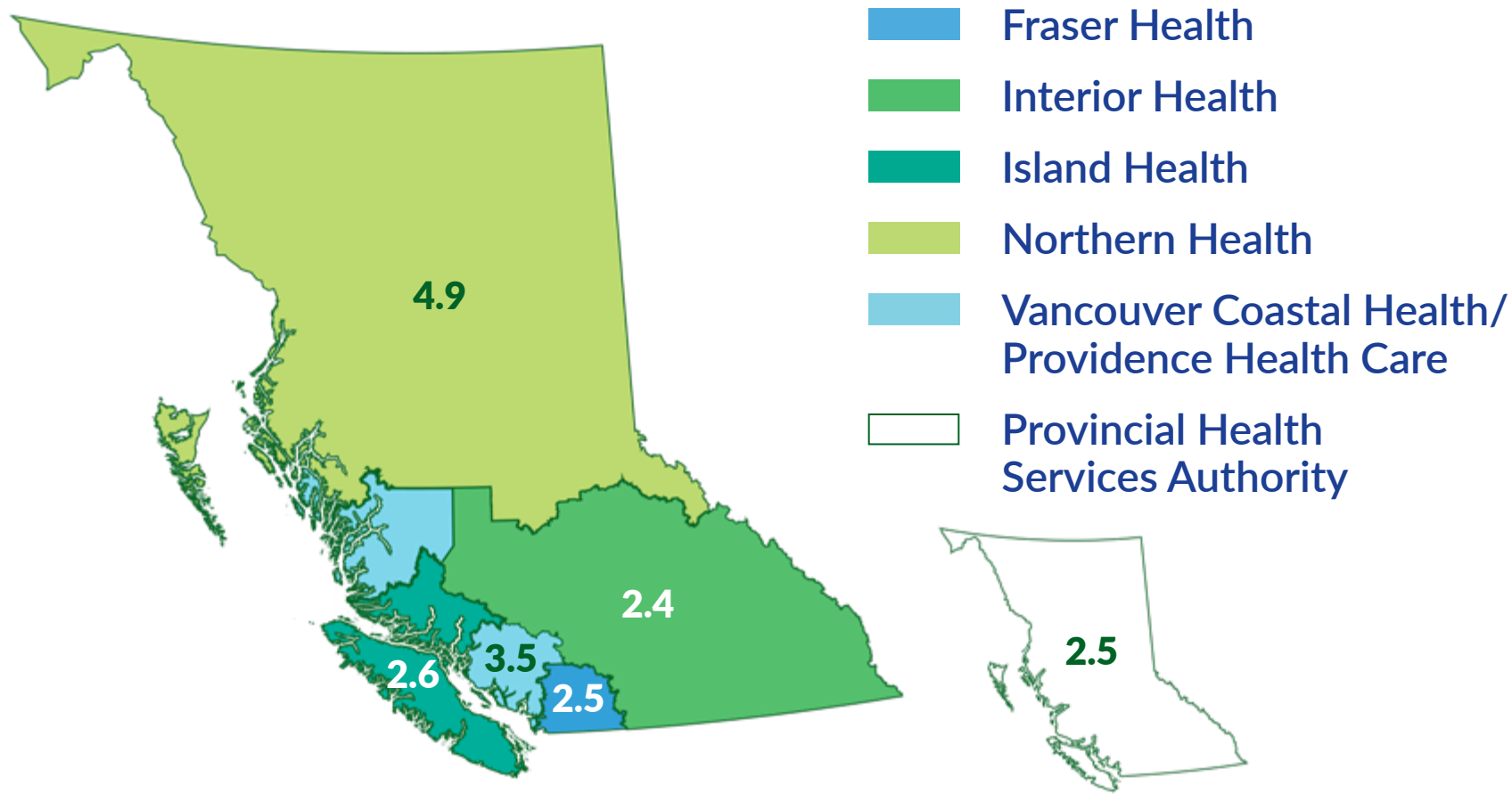
from 2.7 to 2.9 per 10,000 inpatient days since the same quarter last year

52.1% of CDI episodes were new cases associated with the reporting facility

Provincial rate of new CDI cases associated with the reporting facility, by fiscal year and quarter, 2021/22 – 2025/26



Rate of new CDI cases (per 10,000 inpatient days) associated with the reporting facility by health authority, Q1 of 2025/26

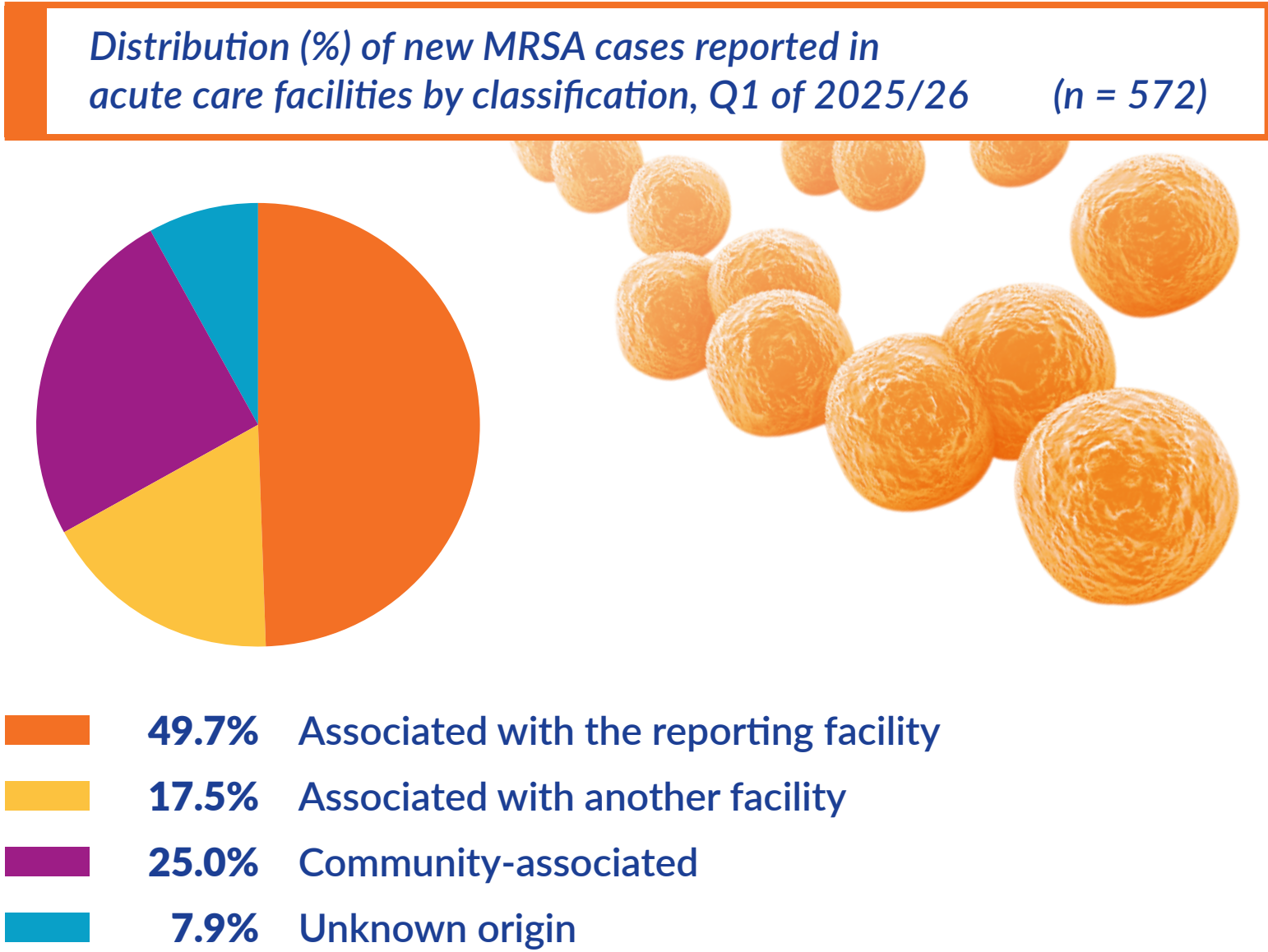


! Comparisons across health authorities should be avoided due to variations in applying the provincial surveillance protocol, case finding strategies, patient demographics and risk profile and services provided.

Methicillin-Resistant *Staphylococcus aureus* (MRSA)

MRSA is a type of bacteria that is resistant to many antibiotics. MRSA often lives on the skin or in the nose of healthy people without causing symptoms (colonization). It can, however, cause pneumonia, bloodstream infections, surgical site infections, and other infections associated with invasive medical procedures and devices.

MRSA cases (colonization or infection) identified for the first time from inpatients in acute care facilities are under provincial surveillance.



HIGHLIGHTS



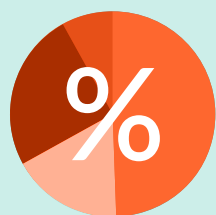
3.5 per 10,000 inpatient days

Quarterly provincial rate of new MRSA cases associated with the reporting facility



Provincial rates of MRSA have increased

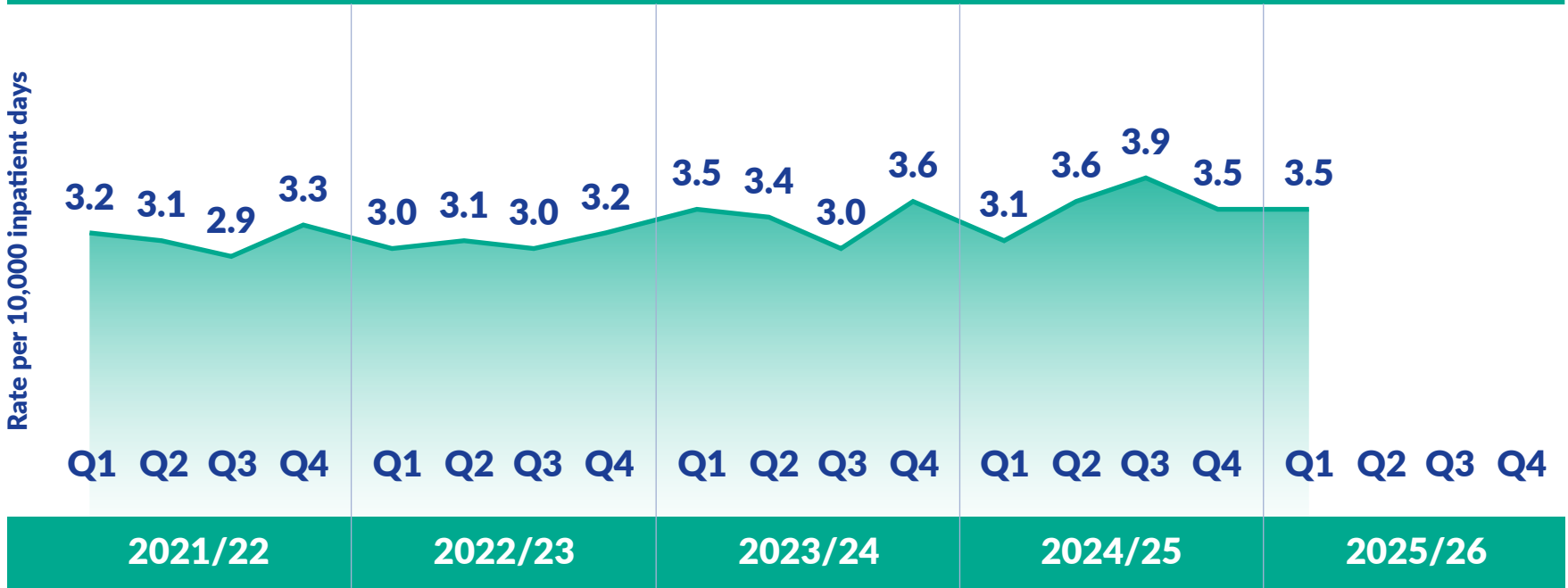
from 3.1 to 3.5 per 10,000 inpatient days since the same quarter last year



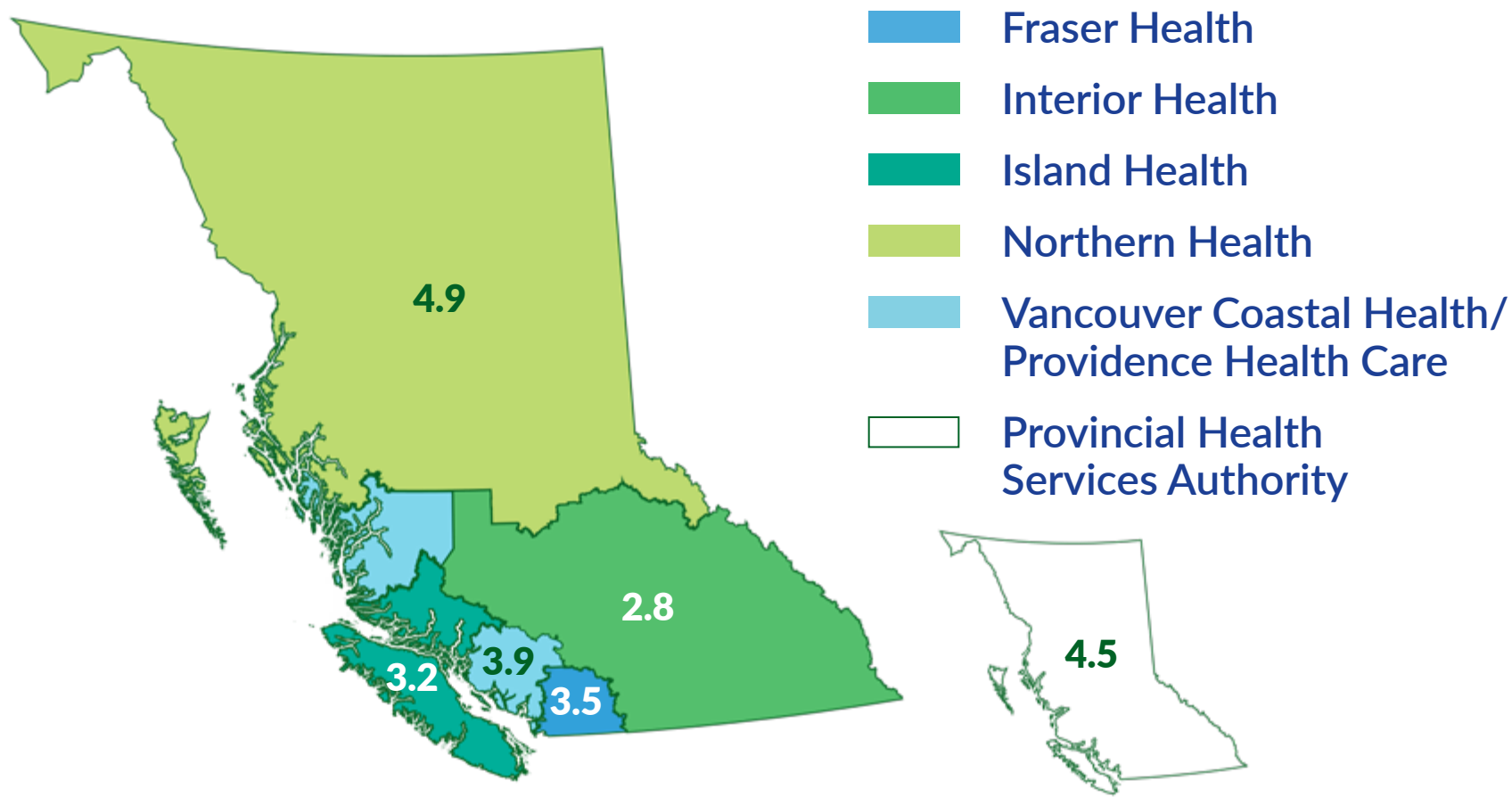
49.7%

New MRSA cases associated with the reporting facility

Provincial rate of new MRSA cases associated with the reporting facility, by fiscal year and quarter, 2021/22 – 2025/26



Rate of new MRSA cases (per 10,000 inpatient days) associated with the reporting facility by health authority, Q1 of 2025/26



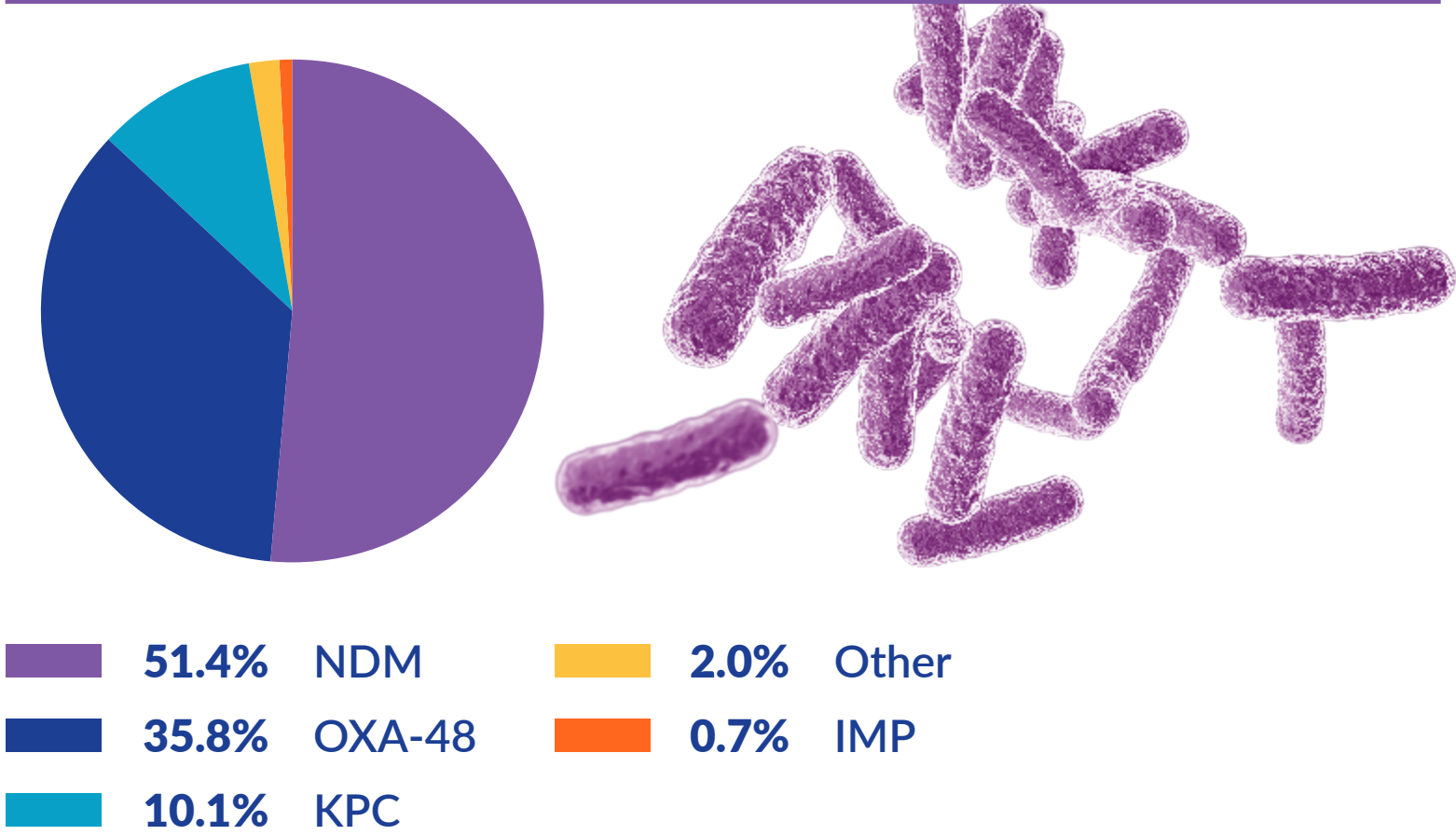
! Comparisons across health authorities should be avoided due to variations in applying the provincial surveillance protocol, case finding strategies, patient demographics and risk profile and services provided.

Carbapenemase-Producing Organisms (CPO)

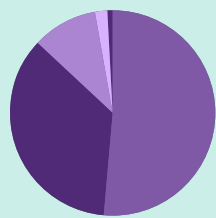
CPO are bacteria often naturally found in the gut that have become resistant to carbapenems, a class of broad spectrum antibiotics usually reserved to treat serious infections when other antibiotics have not worked. When spread from the gut to other parts of the body such as the blood, lungs, or bladder, these multi-drug-resistant bacteria can cause infections that are difficult to treat.

Each carbapenemase gene newly identified from a given patient with CPO colonization or infection is considered a new case. CPO cases are reportable to public health in BC.

Distribution (%) of new CPO cases by gene classification, Q1 of 2025/26 (identified from 127 new patients) (n = 148)

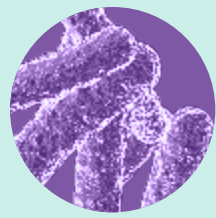


HIGHLIGHTS



148 new cases

- Identified from 127 patients
 - 106 patients harboured 1 gene
 - 21 patients harboured 2 genes
- 118 new cases had surveillance information



NDM

Most commonly identified gene



42 out of 118 cases






(With surveillance information available)

Had a previous encounter with a health care facility in BC

*With surveillance information available
**Exposures are not mutually exclusive

⚠ Comparisons across health authorities should be avoided due to variations in population at risk and screening policy for CPO.

Number of new CPO cases with available surveillance information, identified in health care facilities, Q1 of 2025/26 (n = 118 cases)*

Setting	Number of new cases identified				
Acute care by health auth.					
Fraser Health	67		NDM 31	OXA-48 31	KPC 5
Interior Health	2		NDM 1	OXA-48 1	
Island Health	13		NDM 11	OXA-48 1	KPC 1
Northern Health	0				
Vancouver Coastal Health/ Providence Health Care	22		NDM 9	OXA-48 7	KPC 6
PHSA	0				
Community care	14		NDM 8	OXA-48 4	Other 2

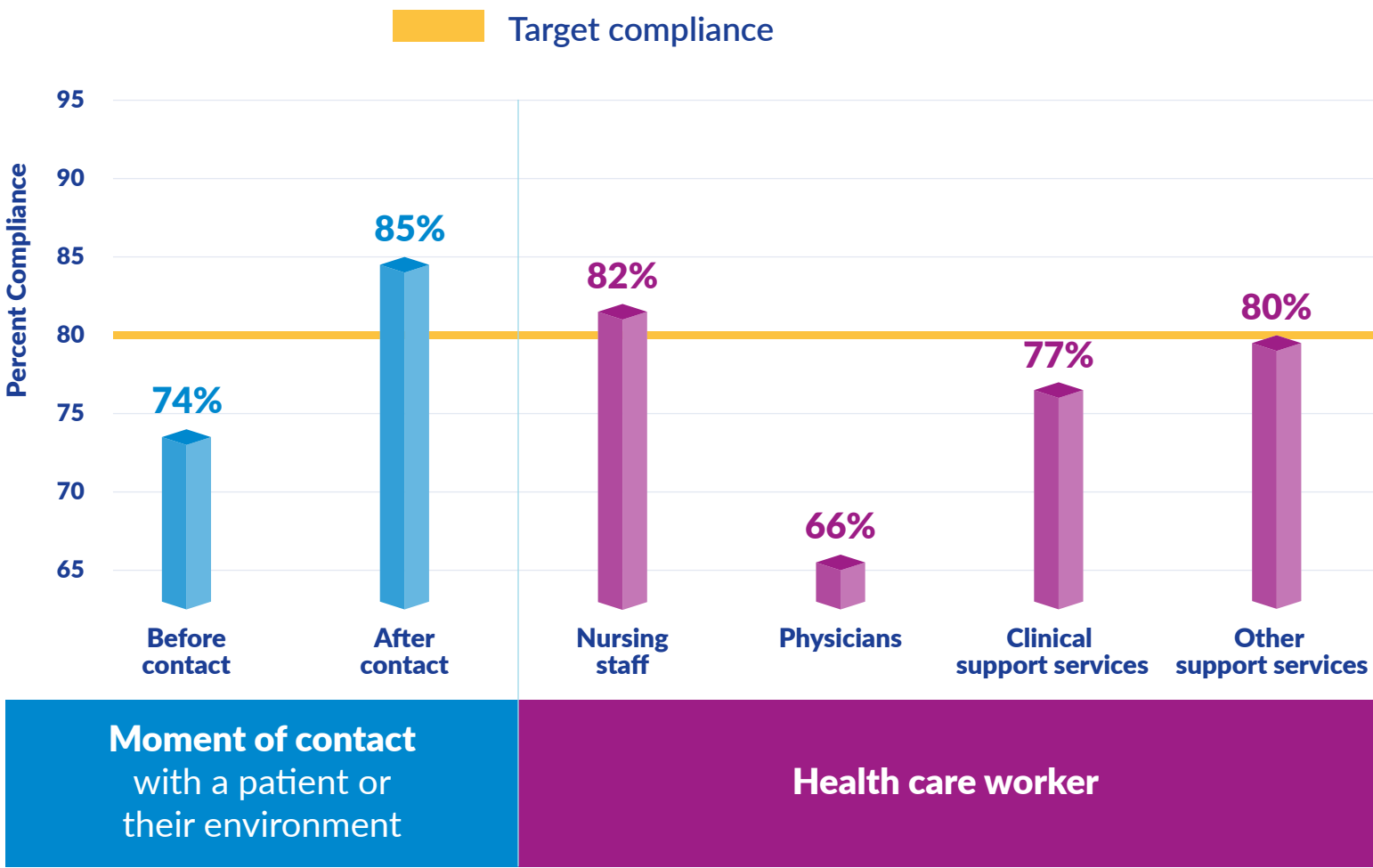
Exposure information** for new CPO cases, Q1 of 2025/26 (n = 118 cases)*

Exposures in the previous 12 months	Number of cases	
Previous encounter with a health care facility in BC	42	<div><div></div></div>
Travel outside of Canada	85	<div><div></div></div>
Health care encounter outside of Canada	48	<div><div></div></div>
Transmission investigation in the reporting facility	8	<div><div></div></div>
Contact with a known CPO case	11	<div><div></div></div>
No exposures reported	8	<div><div></div></div>

Hand Cleaning Compliance

Improving hand cleaning compliance among health care workers is key to reducing health care-associated infections. Reporting on compliance provides transparency to the public and assists health care facilities in quality improvement.

Hand cleaning compliance in acute care facilities by moment of contact and health care worker, Q1 of 2025/26



HIGHLIGHTS

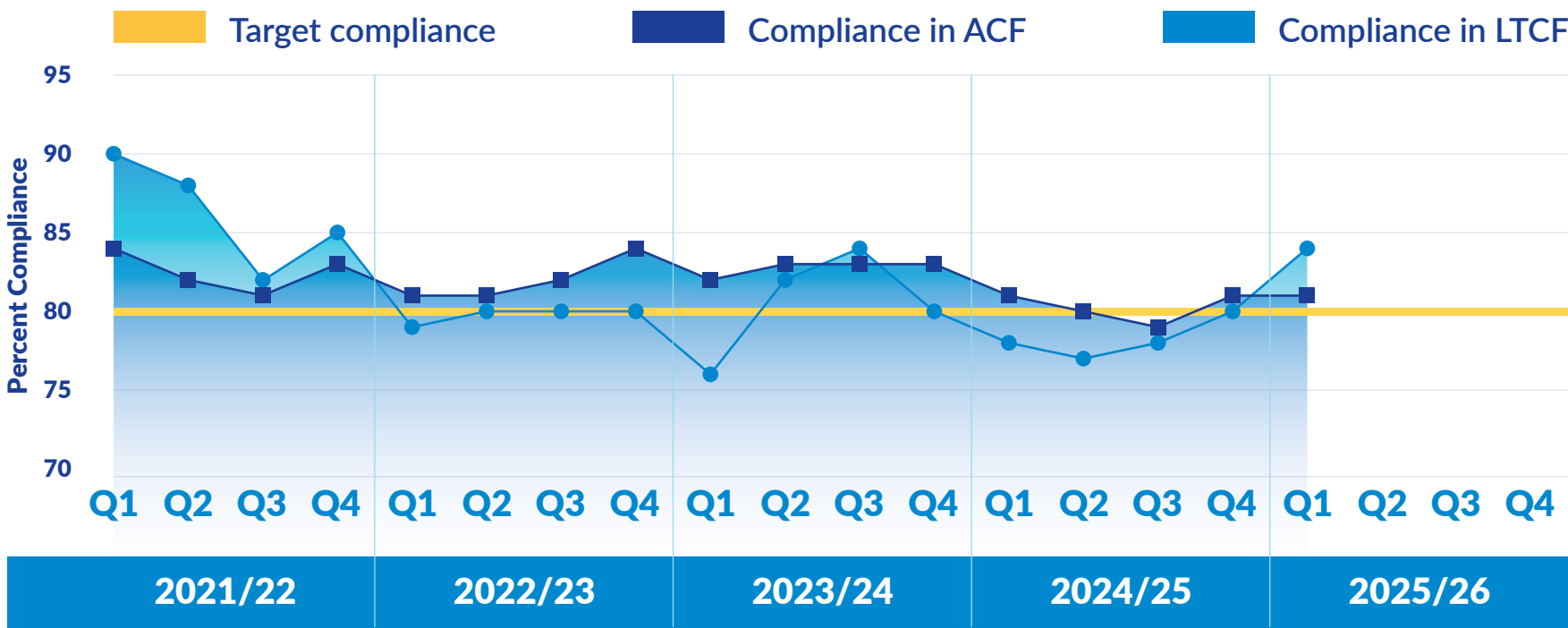
Overall provincial hand cleaning compliance:
81% in acute care
84% in long-term care

74% compliance **before contact** with the patient
85% compliance **after contact** with the patient/patient environment

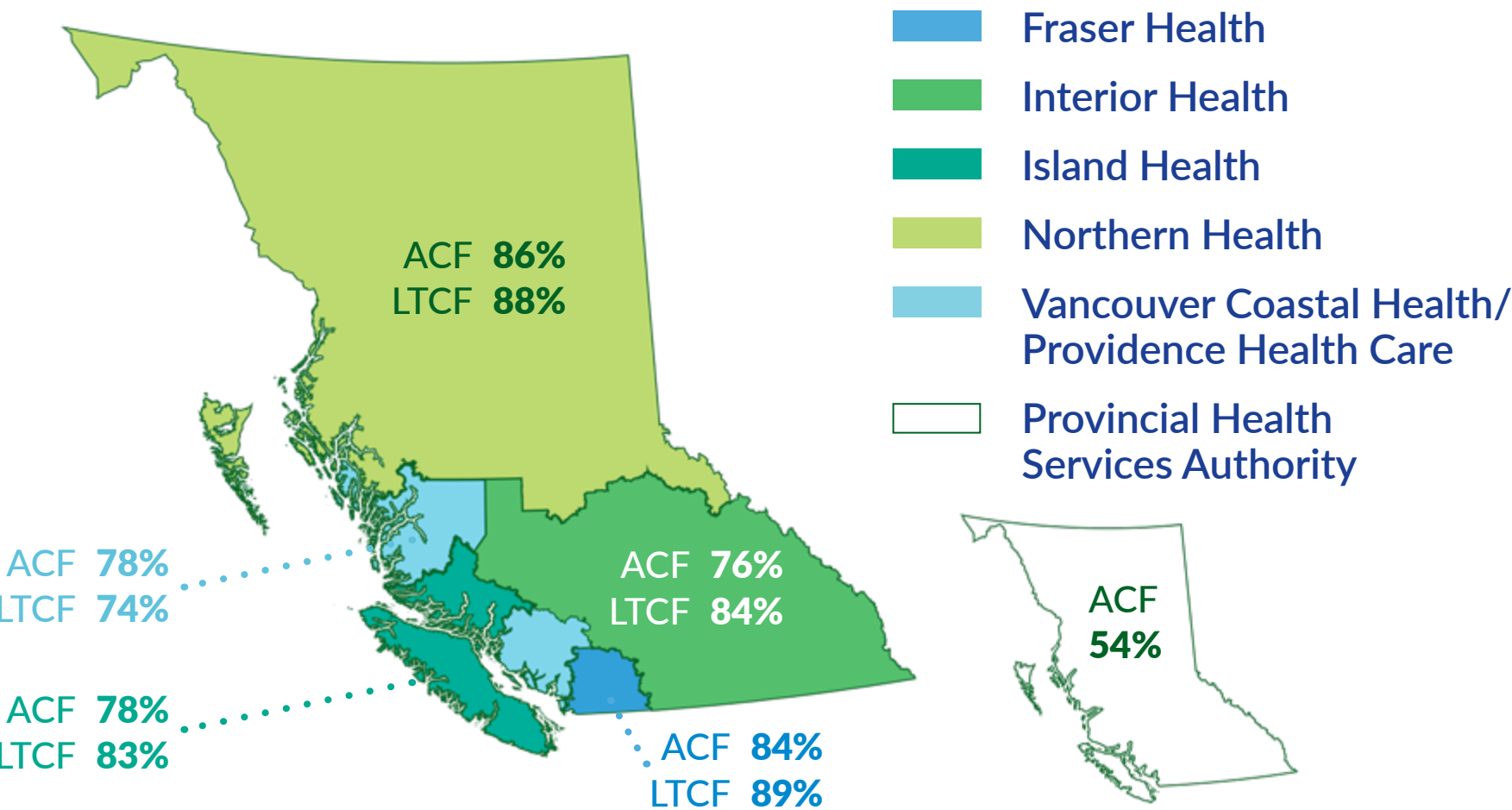
Hand cleaning compliance was **lowest for physicians at 66%**

⚠ Comparisons across health authorities and facility types should be avoided due to potential observer bias, Hawthorne effect, and variations in audit methods.

Provincial hand cleaning compliance among health care workers in acute care facilities (ACF) and long-term care facilities (LTCF) by quarter and year, 2021/22 – 2025/26



Hand cleaning compliance by health authority, Q1 of 2025/26



Technical Notes

1. The provincial surveillance program for infection prevention and control (IPC) is a collaboration between PICNet and BC health authorities. Provincial surveillance protocols for *Clostridioides difficile* infection (CDI), Methicillin-resistant *Staphylococcus aureus* (MRSA) and Carbapenemase-producing organisms (CPOs) are available on the PICNet website: picnet.ca/surveillance.
2. Provincial surveillance data for CDI, MRSA and hand cleaning compliance are collected by health authorities, aggregated by health care facility and quarter, and reported to PICNet. Provincial surveillance data for CPO are submitted to PICNet at the case level by health authorities or care providers in community care settings.
3. Data are presented by fiscal quarter, as defined by financial departments across health authorities. The exceptions are CDI, MRSA and hand cleaning compliance data from Provincial Health Services Authority and hand cleaning compliance data from Interior Health, which are aggregated by calendar quarter. The time frame of each fiscal quarter varies by fiscal year. Generally, the fourth fiscal quarter (Q4) is longer than the other three quarters (Q1, Q2, and Q3).
4. CDI episodes and new MRSA cases are classified as health care-associated or community-associated according to patients' encounters with a health care facility in the previous four weeks (CDI) or 12 months (MRSA).
5. Health care-associated CDI episodes among inpatients in acute care facilities (ACFs) are further classified as new cases or relapses based on the time frame of the episodes. A relapse may include recurrence of a previous CDI, re-infection with the same strain, or infection with a different strain of *C. difficile* that occurs between two and eight weeks after a previous health care-associated CDI episode.
6. CDI episodes among inpatients in acute care facilities that are classified as community-associated include both new cases and relapses.
7. Health authorities have adopted a two-step testing approach for CDI, which includes an initial screening test followed by a confirmatory test, at different times: Fraser Health began in October 2023, Interior Health in February 2022, Island Health in October 2018, Northern Health in November 2023, Providence Health Care in January 2017, Provincial Health Services Authority in December 2023, and Vancouver Coastal Health in June 2023. This two-step testing method may lead to higher reported CDI cases due to its increased sensitivity.
8. A new MRSA case is defined as a colonization or infection identified for the first time in an inpatient in an acute care facility. MRSA infections identified in inpatients with previous MRSA colonization are not included.
9. Facilities in PHSA and PHC are unable to check patient health care history outside their health authority, and thus did not report CDI cases that were associated with another facility (new and relapse). Some other health authorities (VCH, PHC, IH) don't report (or collect) community associated and/or unknown type data for CDI.
10. PHC don't report MRSA cases associated with another reporting facility and community-associated cases. IH don't collect unknown subtype data while VCH neither collect unknown nor community cases data for MRSA.
11. CPO infections and colonizations are reportable to public health in BC. All CPO-suspect isolates are required to be sent to BC Centre for Disease Control Public Health Laboratory (PHL) for molecular testing and genotyping. CPO testing results are then obtained from the PHL's laboratory information system.
12. A new CPO case is defined as a carbapenemase gene that was identified for the first time from a given patient in the province. Different genes identified from the same patient are considered different cases.
13. Surveillance forms are required to be completed for new CPO cases (colonizations and infections) identified in both acute and community care settings and submitted to PICNet by health authorities or health care providers in community care settings, such as outpatient clinics, emergency departments, long-term care or assisted living facilities and community clinics. Surveillance information is not available for a minority of CPO cases due to administrative challenges. Exposure information is reported only for the cases where surveillance information is available.
14. New CPO cases are reported based on where they were identified and reported, i.e. acute care facility in a health authority or community care setting.
15. Exposure information collected on CPO surveillance forms includes: travel outside Canada, health care encounters outside Canada and within BC, ongoing CPO transmission investigation in a patient care unit, and contact with a known CPO case or CPO in the environment in the previous twelve months. These exposures are not mutually exclusive.
16. Hand cleaning compliance is audited by health authorities. The percentage score reports how often, during an audit, health care workers clean their hands before and after contact with a patient or the patient environment, such as changing bed linen, touching a bed rail or clearing a bedside table.

Technical Notes

17. The expectation for hand hygiene compliance is 100% for both before and after contact with the patient and patients' environment for each health care worker group. The provincial target of 80%, established by the Provincial Hand Hygiene Working Group, is a minimum standard health authorities should meet while striving for continuous quality improvement.
18. In acute care facilities, trained auditors observe a sample of health care workers and record whether they clean their hands at the appropriate times.
19. Health care workers in ACFs are grouped into four categories:
 - 1) Nursing staff, including registered nurse, midwife, licensed practical nurse, care aide, and nursing/midwife student
 - 2) Physicians, including medical doctor, resident, fellow, medical student, and nurse practitioner
 - 3) Clinical support services, including occupational therapist, physiotherapist, respiratory therapist, speech therapist, social worker, dietician, psychologist, audiologist, porter, pastoral care, radiologist, and technician (e.g., ECG, EEG, phlebotomy)
 - 4) Other support services, including house keeping, food services, and clerk
20. Due to the COVID-19 pandemic, compliance data from some health authorities acute care facilities were not available during the following periods:
 - FH (Q4 of 2019/20 to Q2 of 2020/21),
 - IH (Q1 of 2020/21), PHC (Q4 of 2019/20), and
 - VCH (Q4 of 2019/20 to Q3 of 2020/21).
21. Hand cleaning compliance (HCC) is audited in long-term care facilities (LTCFs) that are owned or operated by a health authority. Audit data are voluntarily reported by health authorities to PICNet for public reporting.
22. HCC audits were suspended in some health authorities LTCFs due to the COVID-19 pandemic response. Compliance data in all LTCFs in Interior Health are not available from Q1 of 2020/21 to Q2 of 2021/22. No audits were done in PHC's LTCFs from Q4 of 2019/20 Q4 to Q1 of 2021/22; HCC audits resumed in Q2 of 2021/22.
23. From Q2 of 2018/19 through Q4 of 2022/23, Fraser Health only reported observations performed by regional hand hygiene auditors in acute care facilities to PICNet. As a result, compliance data are unavailable for all LTCFs in Fraser Health for that time period.
24. There are no LTCFs owned or operated by Provincial Health Services Authority. Provincial Health Services Authority's hand cleaning compliance audit methods were modified during Q1 of 2021/22.
25. Hand cleaning compliance is audited through direct observation in both acute care facilities and LTCFs; however, audit strategies and methods vary across health authorities and over time. Auditors are trained by health authorities and include dedicated hand hygiene auditors or coordinators, infection prevention and control professionals, university co-op students, and staff within health care facilities (self-auditing). Observer bias and Hawthorne effect (i.e. behaviour changes due to awareness of being observed) may occur during auditing.

26. For more details on surveillance methods and data limitations, please refer to the most recent annual surveillance report at picnet.ca/surveillance.
27. For all health authority categorizations in this report, Providence Health Care data is grouped with Vancouver Coastal Health data.



There is variation across health authorities in applying the provincial surveillance protocols, case finding strategies, patient mix and services provided as well as hand cleaning compliance audit methods. Therefore, comparison of numbers or rates of CDI, MRSA, or CPO, or hand cleaning compliance between health authorities should be avoided.

DISCLAIMER

The purpose of this report is to provide information to health care workers, decision-makers, patients, and the public to inform IPC policy and practice in BC health care facilities. This report may be used, in whole or in part, for quality improvement and patient safety. PICNet does not warrant or assume any legal liability or responsibility for the accuracy, completeness, or usefulness of any information in the report; neither does it intend to provide specific medical advice. Commercial uses are prohibited without express written permission.