Prince Edward Island
CANADA

Health and Wellness

Prince Edward Island Guidelines for Antimicrobial-Resistant Organisms (AROs) in Long-Term Care And Community Care Facilities

May 2026

Department of Health and Wellness
Chief Public Health Office

Contents

1.0 Introduction 5
2.0 Background 5
2.1 Hierarchy of Controls in IPAC 6
3.0 Reporting Requirements 6
3.1 Facility Operators/Staff 6
3.2 Laboratory 6
4.0 Summary of Antimicrobial-Resistant Organisms (AROs) 7
4.0.1 Definition: Modified Contact Precautions (MCP) 7
4.1. Colonization, Infection and Transmission 8
4.1.1 Colonization Versus Infection 8
4.1.2 Common AROs – Colonization Sites and Infections 9
4.1.3 Transmission 9
4.2 Methicillin-resistant *Staphylococcus aureus* (MRSA): 10
4.3 Vancomycin-Resistant *Enterococci* (VRE) 10
4.4 Other AROs 11
4.4.1 Carbapenemase-Producing *Enterobacterales* (CPE) 11
4.4.2 *Candida auris* (*C. auris*) 11
5.0 Routine Screening for MRSA and VRE 12
5.1 Admission Screening for MRSA 12
5.1.1 Risk Factors for MRSA Colonization/Infection 12
5.1.2 Specimen Collection for MRSA 12
5.2 Admission Screening for VRE 12
5.2.1 Risk Factors for VRE Colonization/Infection 12
5.2.2 Specimen Collection for VRE 13
5.3 Ongoing Culturing for MRSA and VRE 13
5.4 Decolonization for MRSA and VRE in LTC and CC 13
5.5 Managing ARO Cases 14
5.5.1 General Principles 14

5.5.2 Accommodation and Precautions 14
5.5.3 Environmental Cleaning 14
5.5.4 Communication and Transfer Protocols 14
5.5.5 Outbreak Management 15
6.0 Outbreak Management for AROs 15
6.1 Outbreak Definition 15
6.2 Outbreak Closure Criteria 16
7.0 Communication and Reporting Protocols 16
8.0 Roles and Responsibilities 17
9.0 Education and Training 17
References 18
Appendix A: Hand Hygiene 19
Appendix B: Point-of-Care Risk Assessment (PCRA) + Algorithm for all Resident Interactions 20
Appendix C: Modified Contact Precautions (MCP) 21
Appendix D: Resident Risk Assessment for AROs 22
Appendix E: Specimen Collection 23
Appendix F1: Technical Reference / Management of ARO-Positive Residents 24
Appendix F2: Quick Reference Poster / Management of ARO-Positive Residents 27
Appendix G1: Technical Reference / ARO Outbreak Management in LTC and CC 28
Appendix G2: Quick Reference Poster / ARO Outbreak Management 30
Appendix H: Outbreak Signage 31
Appendix I: ARO Line List 32

EXECUTIVE SUMMARY

Antimicrobial-Resistant Organisms (AROs) such as methicillin-resistant Staphylococcus aureus (MRSA), vancomycin-resistant *Enterococcus* (VRE), carbapenemase-producing *Enterobacterales* (CPE), and *Candida auris* (*C. auris*)present ongoing challenges in long-term care (LTC) and community care (CC) settings. This guideline provides standardized, evidence-based direction for the prevention, screening, management, and outbreak control of AROs across Prince Edward Island's LTC and CC settings.

The guideline emphasizes Routine Practices and Point-of-Care Risk Assessment (PCRA) as the foundation of care, with Modified Contact Precautions (MCP) applied for direct care when PCRA and resident transmission risk indicate increased risk of transmission. A resident-centered, risk-based approach is prioritized to prevent transmission while preserving dignity, autonomy, and quality of life. The document outlines reporting requirements, screening criteria, specimen collection, resident management, outbreak response, communication protocols, and staff education, aligned with provincial legislation and national infection prevention and control standards.

The guideline supports, but does not replace, directives issued by the Chief Public Health Office (CPHO), which take precedence during outbreaks or public health events.

1.0 Introduction

Antimicrobial-resistance is an escalating global challenge in infectious disease management. Antimicrobial-resistant organisms (AROs) have existed for decades, but their prevalence has increased substantially in recent decades. The emergence and spread of organisms such as methicillin-resistant *Staphylococcus aureus* (MRSA) and vancomycin-resistant *Enterococcus* (VRE) underscore the need for strong infection prevention and control (IPAC) measures.

The guideline is issued under the authority of the of the Chief Public Health Office (CPHO) and is intended to support compliance with the Public Health Act and applicable regulations in Prince Edward Island.

Effective IPAC strategies in LTC and CC settings help protect residents, improve health outcomes, and reduce operational burdens on care providers. The guideline emphasizes a proportionate, risk-based application of IPAC measures, guided by Routine Practices and PCRA, to minimize transmission risk.

This document provides standardized, evidence-based guidance for the prevention, screening, and management of AROs across Prince Edward Island's LTC and CC facilities. It applies to all facility operators, health care staff, administrators, and affiliated laboratories. The scope includes MRSA, VRE, and other clinically significant AROs such as carbapenemase-producing *Enterobacterales* (CPE) and *Candida auris (C. auris)*.

2.0 Background

AROs are pathogens that have developed mechanisms to survive exposure to antimicrobials that would normally eliminate them. Resistance reduces the effectiveness of standard treatments, leading to infections that are harder to manage and increasing the risk of complications, prolonged illness, and further transmission.

The rise of AROs is a significant public health concern, driven by factors such as antimicrobial overuse and misuse, inadequate IPAC practices, and the natural evolution of microorganisms. In LTC and CC settings, residents are particularly vulnerable due to advanced age, underlying health conditions, and frequent interactions with health care environments.

The most commonly encountered AROs in these settings include:

- MRSA (Methicillin-resistant *Staphylococcus aureus*)
- VRE (Vancomycin-resistant *Enterococcus*)

Additional organisms of concern, addressed to a lesser extent in this document, include:

- Carbapenemase-Producing *Enterobacterales* (CPE) – a subset of carbapenem-resistant *Enterobacterales* (CRE)
- *Candida auris (C. auris)* (drug-resistant)

Effective management of AROs requires a coordinated approach involving surveillance, education, antimicrobial stewardship, and strict adherence to evidence-based IPAC practices. This guidance is intended to support facility policies, procedures, and plans for prevention and management that protect residents, staff, visitors, and volunteers.

2.1 Hierarchy of Controls in IPAC

IPAC strategies are guided by the hierarchy of controls, which prioritizes the most effective measures to reduce transmission risk:

- Administrative controls: Policies, procedures, education, screening, and surveillance
- Engineering controls: Physical environment and infrastructure (e.g., hand hygiene stations, private rooms)
- Personal protective equipment (PPE): Used as the final layer of protection when other controls cannot fully mitigate risk

3.0 Reporting Requirements

MRSA, VRE , CPE, and *C. auris* (drug-resistant) are designated notifiable diseases under the *Prince Edward Island Public Health Act* and the *Notifiable Diseases and Conditions and Communicable Diseases Regulations*.

3.1 Facility Operators/Staff

Health practitioners and facility administrators must promptly notify the Chief Public Health Officer (CPHO) or their designate by telephone of all laboratory-confirmed cases when identified.

3.2 Laboratory

The Provincial Laboratory must promptly notify the Chief Public Health Officer (CPHO) or their designate of all positive laboratory results by telephone, mail, fax, or electronic transfer when the result is known.

4.0 Summary of Antimicrobial-Resistant Organisms (AROs)

4.0.1 Definition: Modified Contact Precautions (MCP)

Modified Contact Precautions (MCP) are a targeted, risk-based approach used in LTC and CC settings when PCRA and an individualized resident transmission risk indicate an increased risk of transmission.

MCP are applied to direct care activities and to interactions involving the resident's immediate care environment where there is a reasonable expectation of contact with blood, body fluids, secretions, excretions, or contaminated surfaces.

MCP are not determined by ARO status alone and do not automatically require precautions or private-room placement.

MCP are applied based on the task and anticipated exposure during care, not applied continuously to the resident, and are reassessed regularly. When the increased transmission risk is no longer present, MCP are discontinued and care returns to Routine Practices supported by PCRA.

Direct care (for MCP) includes hands-on care activities such as bathing, turning/positioning, changing clothes or incontinence products, toileting, dressing changes, and care of open wounds or lesions. Activities such as assisting with feeding or pushing a wheelchair are not considered direct care and do not routinely require MCP.

4.1. Colonization, Infection and Transmission

Understanding the relationship between colonization, infection and transmission is essential for appropriate IPAC decision-making in LTC and CC setting.

4.1.1 Colonization Versus Infection

Colonization is a significant contributor to transmission risk and must be considered in both routine management and outbreak recognition.

- **Colonization**: Presence and growth of AROs on or in a host without causing tissue invasion, symptoms, or disease (e.g., skin, mucous membranes, gastrointestinal tract)
- **Infection**: Invasion of body tissues by an ARO that causes clinical signs and symptoms

This distinction guides clinical management, antimicrobial use, and IPAC measures, including PCRA, and MCP.

Table 1 Colonization Vs Infection

Feature	Colonization	Infection
Definition	Presence of AROs without illness	Invasion and multiplication causing tissue damage and symptoms
Symptoms	None	Present (e.g. fever, inflammation, pain, wound drainage)
Immune Response	Typically absent	Active immune response
Diagnostic Tests	Positive culture without clinical signs	Positive culture with clinical signs
Treatment Required	Usually not required	Required (antimicrobial therapy, supportive care)
Transmission Risk	High (often unrecognized)	High (especially with wounds/devices or uncontained secretions)
Common Sites	Skin, nasal passages, GI tract, urinary tract	Depends on infection site (e.g., lungs, bloodstream, wounds, urinary tract)
IPAC Measures	Screening and surveillance, Routine Practices, MCP (when indicated based on PCRA and resident transmission risk), hand hygiene, environmental cleaning and disinfection, and antimicrobial stewardship	MCP (when indicated based on PCRA and resident transmission risk), treatment, enhanced IPAC measures as required, environmental cleaning and disinfection, and antimicrobial stewardship
Progression Potential	May progress to infection if host defenses are compromised	Already progressed to disease

4.1.2 Common AROs – Colonization Sites and Infections

Understanding colonization patterns supports risk assessment and targeted interventions, as colonization can precede infection and may serve as a reservoir for transmission.

Table 2 Common AROs- Colonization Sites and Infections

ARO Name	Type	Common Colonization Sites	Common Infections Caused
MRSA (Methicillin-resistant *Staphylococcus aureus*)	Bacteria	Skin, nasal passages, perianal area, wounds	Skin/soft tissue infections, wounds, UTIs, pneumonia, bloodstream infections, surgical site infections
VRE (Vancomycin-resistant *Enterococcus*)	Bacteria	GI tract, perineum	UTIs, bloodstream infections
CPE (Carbapenemase-producing *Enterobacterales*)	Bacteria	GI tract	Sepsis, pneumonia, UTIs, intra-abdominal infections
***C. auris (Candida auris)* (drug-resistant)**	Fungus	Skin (axilla/groin), external ear canal	Bloodstream infections, wound infections, ear infections

4.1.3 Transmission

Understanding transmission pathways is essential for effective IPAC. AROs are primarily spread through contact—either direct or indirect—and transmission may be facilitated by invasive procedures if aseptic technique is compromised.

Table 3 Mode of Transmission

Mode of Transmission	Description
Direct Contact	Most common route. Spread via hands of healthcare workers or direct contact with colonized/infected individuals. Common in LTC and CC settings where residents are in close proximity. Invasive procedures (e.g., hypodermoclysis insertion, dressing changes) increase risk if aseptic technique is compromised.
Indirect Contact	Transmission via contaminated surfaces, equipment, or shared items (e.g., blood pressure cuffs, thermometers, bed rails, linens). AROs such as *C. auris* and CPE can persist on surfaces and in the environment for extended periods.

4.2 Methicillin-resistant *Staphylococcus aureus* (MRSA):

MRSA is a strain of *Staphylococcus aureus* that has developed resistance to several commonly used antibiotics, including methicillin, oxacillin, penicillin, and amoxicillin. It is a major cause of healthcare-associated infections (HAIs) and a significant public health concern due to its ability to cause severe illness and its resistance to treatment.

Like non-resistant *S. aureus*, MRSA can colonize individuals without causing symptoms. Colonization typically occurs in the anterior nares, skin, and other mucosal surfaces. While 25–30% of the population may be colonized with *S. aureus*, approximately 1–2% are colonized with MRSA.

Colonized individuals can transmit MRSA to others, particularly in healthcare settings. Colonization may progress to infection when host defenses are compromised, such as through wounds, invasive devices, or immunosuppression.

Common HAIs Include:

- Skin and soft tissue infections
- Surgical site infections
- Pneumonia
- Bloodstream infections (Bacteremia)
- Urinary tract infections (UTIs)

Treatment Challenges

MRSA infections are difficult to treat due to resistance to beta-lactam antibiotics. Treatment options include agents such as vancomycin, linezolid, daptomycin, and clindamycin, selected based on infection severity, site, and resident-specific factors. Combination therapy may be considered for complicated infections. Antimicrobial stewardship is essential to prevent further resistance.

4.3 Vancomycin-Resistant *Enterococci* (VRE)

Enterococci are Gram-positive, facultative anaerobic cocci that naturally inhabit the gastrointestinal tract and may also be found in the anterior urethra, vagina, skin, oropharynx, and bile. While generally harmless, they can colonize wounds, ulcers, and medical devices and are a frequent cause of HAIs.

VRE are strains of *Enterococcus faecalis* and *Enterococcus faecium* that have developed resistance to vancomycin, a key antibiotic for treating serious enterococcal infections. This resistance is primarily due to genetic mutations—most notably the **vanA**, **vanB**, and **vanD** gene clusters—which alter the bacterial cell wall and reduce vancomycin's effectiveness.

Common HAIs Include:

- UTIs
- Bacteremia
- Endocarditis

Treatment Challenges

VRE infections are difficult to treat due to limited antibiotic options. Treatment options include agents such as linezolid or daptomycin, with dosing tailored to infection severity and resident-specific factors. Combination therapy with beta-lactams may enhance effectiveness in severe cases.

4.4 Other AROs

Beyond MRSA and VRE, other emerging antimicrobial-resistant organisms pose significant challenges in LTC and CC settings. This section highlights two key organisms—Carbapenemase-Producing *Enterobacterales* (CPE) and *Candida auris (C. auris)*—including their clinical relevance and implications for infection prevention and control.

4.4.1 Carbapenemase-Producing *Enterobacterales* (CPE)

CPE are a subset of carbapenem-resistant *Enterobacterales* that produce carbapenemase enzymes, which break down carbapenem antibiotics and render them ineffective. This resistance makes CPE highly challenging to treat and a major concern for healthcare facilities.

Common species include:

- *Escherichia coli* (*E. coli*)
- *Klebsiella* species
- *Enterobacter* species

Common HAIs Include:

- Bacteremia
- Pneumonia
- UTIs
- Intra-abdominal infections

Treatment Challenges

CPE infections are extremely difficult to treat due to resistance to nearly all beta-lactam antibiotics, including carbapenems. Options include **ceftazidime-avibactam**, **meropenem-vaborbactam**, or **tigecycline**, often in combination therapy. Strict antimicrobial stewardship and enhanced IPAC measures are essential.

4.4.2 *Candida auris* (*C. auris*)

C. auris is an emerging multidrug-resistant fungal pathogen capable of colonizing the skin, particularly in warm, moist areas such as the axillae and groin. It can cause severe invasive infections, especially in hospitalized or immunocompromised individuals. *C. auris* spreads easily in healthcare environments and demonstrates resistance to multiple antifungal medications and common disinfectants.

Common HAIs Include:

- Bacteremia
- Wound infections
- Ear infections

Treatment Challenges

C. auris often exhibits resistance to azoles, polyenes, and sometimes echinocandins. First-line therapy typically involves **echinocandins**, with liposomal amphotericin B reserved for resistant cases. Environmental persistence requires rigorous cleaning and disinfection using products effective against *C. auris*, in accordance with facility policy and IPAC/CPHO guidance.

5.0 Routine Screening for MRSA and VRE

- Routine universal admission screening for MRSA and VRE is not recommended; targeted, risk-based screening should be used
- Routine Practices and PCRA remain the foundation of prevention and are applied consistently for all residents
- Screening must not be used to determine admission, placement, or access to care

5.1 Admission Screening for MRSA

5.1.1 Risk Factors for MRSA Colonization/Infection

Screening should be considered for residents with one or more of the following risk factors:

- History of MRSA colonization or infection
- Health care exposure outside Canada within the past 12 months
- Transfer from a unit or facility with a known MRSA outbreak

Note: When risk factors are present or while awaiting results, apply Routine Practices and PCRA. Apply MCP for direct care when PCRA and the resident transmission risk indicate increased risk of transmission.

5.1.2 Specimen Collection for MRSA

Collect specimens from multiple sites for highest yield:

1. Nares
2. Perianal
3. Skin lesions, wounds, ulcers, surgical incisions, or exit sites of indwelling devices (if present)

Collection guidelines:

- Maximum of four different sites per resident
- Notify the laboratory if >4 sites require testing
- Always use aseptic technique

Note: Urine specimens are not part of routine MRSA screening. Collect urine only when clinically indicated (e.g., signs/symptoms of urinary tract infection), in accordance with clinical assessment and facility policy.

5.2 Admission Screening for VRE

5.2.1 Risk Factors for VRE Colonization/Infection

Screening should be considered for residents with one or more of the following risk factors:

- History of VRE colonization or infection
- Health care exposure outside Canada within the past 12 months
- Transfer from a unit or facility with a known VRE outbreak

Note: When risk factors are present or while awaiting results, apply Routine Practices and PCRA. Apply MCP for direct care when PCRA and the resident transmission risk indicate increased risk of transmission.

5.2.2 Specimen Collection for VRE

Preferred method:

1. Rectal swab with visible stool
2. If a colostomy is present, collect from the colostomy site

Always use aseptic technique for all specimen collections.

5.3 Ongoing Culturing for MRSA and VRE

Routine re-culturing of residents known to be MRSA or VRE positive is not recommended.

Re-culturing may be considered:

- During outbreak investigations
- Prior to transfer to another facility, if required
- When clinically indicated

An antibiotic-free interval (minimum of 48 hours) is required before testing if the individual has received any of the following antibiotics:

- Vancomycin
- Trimethoprim-sulfamethoxazole (cotrimoxazole)
- Doxycycline
- Ciprofloxacin
- Levofloxacin
- Moxifloxacin

Recolonization can occur at any time, even after documented clearance.

5.4 Decolonization for MRSA and VRE in LTC and CC

Routine decolonization for MRSA and VRE is not recommended in LTC and CC settings. The guideline emphasizes IPAC measures rather than routine decolonization strategies.

Rationale

Routine decolonization is discouraged due to:

- Limited effectiveness and high risk of recolonization
- Potential harm to residents
- For MRSA: Low likelihood of sustained clearance in residents with weakened immune systems and multiple chronic conditions
- For VRE: Eradication attempts can disrupt the gut microbiome and increase antimicrobial-resistance risk

Shared IPAC Measures

- Rigorous hand hygiene
- Environmental cleaning and disinfection
- MCP when indicated
- Risk-based screening and surveillance
- Antimicrobial stewardship to prevent resistance

5.5 Managing ARO Cases

Once an ARO is identified or suspected, management strategies focus on reducing transmission risk while supporting resident participation in care and daily activities. Effective management relies on Routine Practices and PCRA, with MCP applied for direct care when PCRA and the resident transmission risk indicate increased risk of transmission, rather than organism status alone.

5.5.1 General Principles

- Apply Routine Practices for all residents
- Perform PCRA before every interaction
- Apply MCP for direct care when PCRA and the resident transmission risk indicate increased risk of transmission

5.5.2 Accommodation and Precautions

Residents who are colonized or infected with MRSA or VRE do not automatically require precautions.

- Routine Practices and PCRA remain the foundation of care.
- MCP are implemented only when the risk of transmission is assessed as higher, such as:
    - Uncontrolled wound drainage or secretions
    - Inability to maintain hygiene despite assistance
    - Frequent uncontained incontinence
    - Behavioural or cognitive challenges affecting containment
- A private room is preferred or required based on transmission risk, not ARO status alone.
- When single rooms are unavailable:
    - Cohort residents with the same organism, or
    - Place with a lower-risk roommate as defined in Appendix F1: Technical Reference / Management of ARO-Positive Residents
- Dedicate resident-specific equipment where possible or clean and disinfect between uses
- Post signage only when MCP are in place

5.5.3 Environmental Cleaning

- Resident rooms and bathrooms are cleaned and disinfected at least daily, with high-touch surfaces cleaned and disinfected more frequently based on risk, environmental contamination, or outbreak direction
- Ensure shared equipment and common areas are cleaned and disinfected after use
- Use hospital-grade disinfectants effective against MRSA and VRE
- For *C. auris*, use disinfectants effective against *C. auris* in accordance with IPAC/CPHO guidance and facility policy

5.5.4 Communication and Transfer Protocols

- Notify receiving facilities of ARO status prior to transfer
- Document organism status clearly in the resident's health record
- Provide education to staff, residents, and families about Routine Practices and MCP if in place

5.5.5 Outbreak Management

Outbreak management for AROs is conducted in collaboration with the CPHO and IPAC.

Facilities must follow the procedures outlined in Appendix G1: Technical Reference / ARO Outbreak Management in LTC and CC, including:

- Outbreak triggers and reporting requirements
- Immediate and enhanced IPAC measures
- Screening and surveillance
- Environmental cleaning and auditing
- Criteria for outbreak closure

See Appendix F1: Technical Reference / Management of ARO-Positive Residents and Appendix F2: Quick Reference Poster / Management of ARO-Positive Residents for detailed technical and PCRA guidance.

6.0 Outbreak Management for AROs

Outbreak management in LTC and CC settings requires a coordinated, risk-based approach that prioritizes resident safety, continuity of care, and timely intervention to prevent transmission.

During outbreaks or public health events, directives issued by the CPHO take precedence over this guidance. All outbreak identification, management, and closure activities must be undertaken in collaboration with the CPHO.

Outbreak measures should be guided by Routine Practices and PCRA, with MCP implemented when the risk of transmission is increased. ARO colonization and infection both contribute to transmission risk and must be considered in outbreak recognition and response.

See Appendix G1: Technical Reference / ARO Outbreak Management in LTC and CC and Appendix G2: Quick Reference Poster / ARO Outbreak Management for detailed outbreak management guidance and visual reference tools.

6.1 Outbreak Definition

An outbreak is:

- A significant increase in cases of colonization or infection with an ARO above the expected baseline for the facility within a defined time period
- Includes epidemiologically linked cases (e.g., same unit or care area)
- Includes both colonized and infected residents, as colonization can contribute to transmission

Key Points

Outbreak thresholds may vary by facility size, resident population, and local epidemiology. Typically, two or more epidemiologically linked cases in the same unit or care area may trigger outbreak protocols. A single case involving a higher-risk ARO (e.g., CPE or *C. auris*) may also trigger outbreak response measures, as directed by IPAC/CPHO.

6.2 Outbreak Closure Criteria

All criteria must be met, in consultation with the CPHO and IPAC:

1. Epidemiological Criteria

- No new cases (colonization or infection) for **≥14 days** after the last positive case was identified and placed on appropriate precautions

2. Enhanced Measures Completed

- Environmental cleaning audits demonstrate compliance
- Hand hygiene audits show sustained adherence
- Staff education and competency verification completed

3. Communication & Documentation

- Outbreak line list updated and finalized
- CPHO (or designated authority) confirms outbreak closure

4. Risk Assessment Supports Closure

- No pending laboratory results or unresolved contacts
- Cohorting and MCP can be safely discontinued, based on PCRA and resident transmission risk

5. Ongoing Surveillance

- Continue active surveillance and hand hygiene audits until the outbreak is officially declared over
- Maintain vigilance for recurrence

6. Resident-Specific Precautions

- For residents who continue to have increased transmission risk on assessment, MCP may remain in place based on PCRA and resident transmission risk, as directed by IPAC/CPHO

7.0 Communication and Reporting Protocols

- **Routine Cases:**
  - Document ARO status in the resident's health record
  - Communicate required measures to the care team and environmental services.
    - Routine Practices and PCRA apply at all times
    - Apply MCP for direct care when PCRA and the resident transmission risk indicate increased risk of transmission
- **Transfers:**
  - Notify the receiving facility of ARO status prior to transfer, including whether MCP are currently in place
- **Outbreaks:**
  - Report suspected or confirmed outbreaks to the CPHO immediately
  - Provide regular updates to staff, residents, and families, as appropriate
- **CPHO Collaboration:**
  - Follow CPHO directives for outbreak declaration and closure, and for any additional IPAC measures

8.0 Roles and Responsibilities

Facility Operators and Administrators

- Ensure IPAC policies are implemented, including Routine Practices and PCRA
- Ensure staff are trained and competent in hand hygiene, PCRA, specimen collection, and the risk-based use of MCP
- Maintain communication with the CPHO and the IPAC team during suspected or confirmed outbreaks

Healthcare Staff

- Apply Routine Practices and perform PCRA before every interaction
- Follow screening, specimen collection, and documentation protocols
- Apply MCP for direct care when PCRA and resident transmission risk indicate increased risk of transmission, and discontinue when no longer indicated

IPAC Team

- Provide guidance on resident transmission-risk assessment, MCP application, cohorting/placement considerations, and outbreak management in collaboration with CPHO
- Monitor and support compliance with hand hygiene and environmental cleaning, including audit and feedback as needed

Laboratories

- Promptly report positive ARO results to the CPHO or designate, in accordance with notifiable disease reporting requirements
- Support outbreak investigations with timely testing and reporting of results

9.0 Education and Training

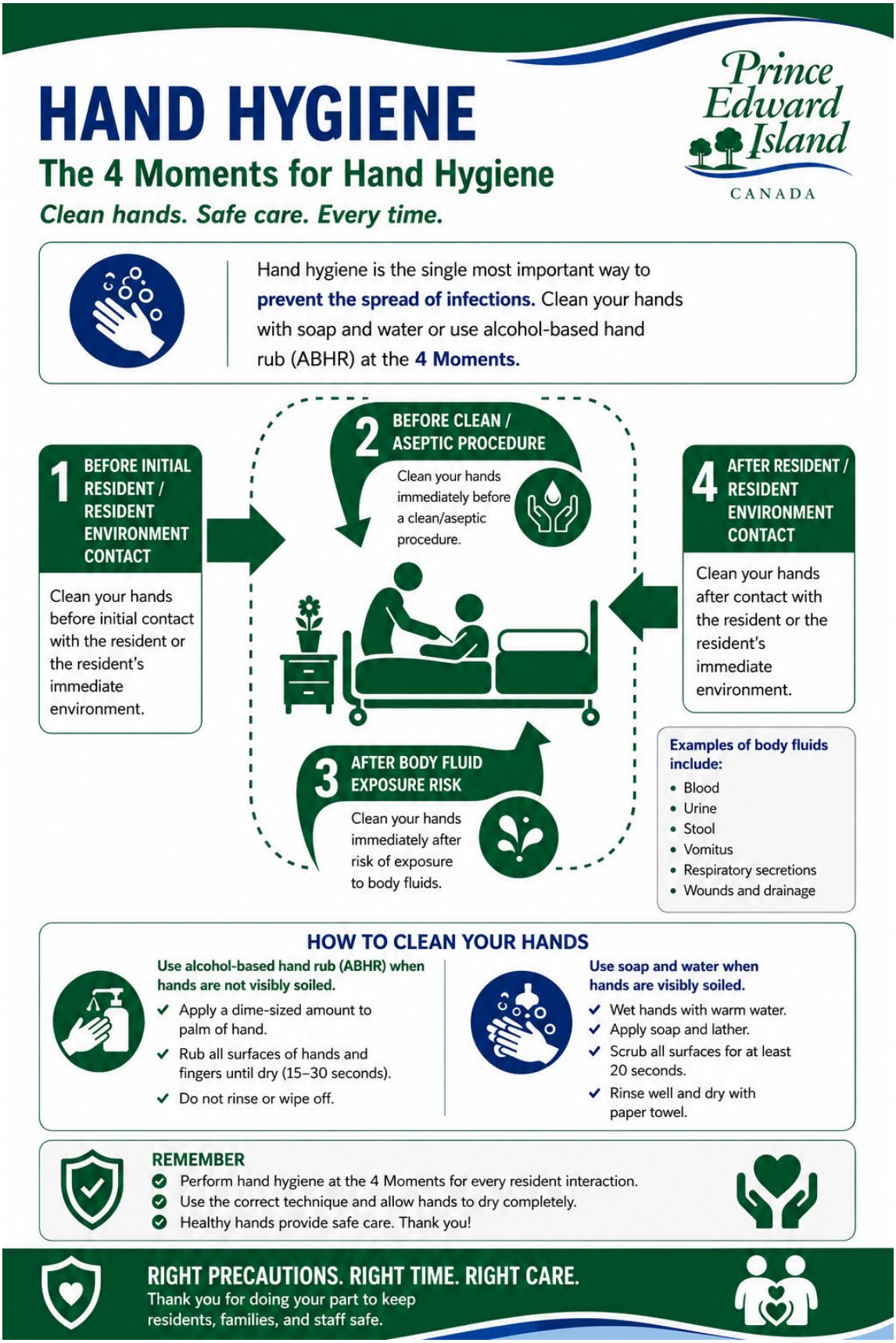
Facilities must ensure:

- Annual IPAC education for all staff, including Routine Practices, hand hygiene, PCRA, task-based PPE selection, and environmental cleaning and disinfection
- Competency validation for specimen collection and outbreak response, including application of MCP for direct care when PCRA and resident transmission risk indicate increased risk of transmission
- Resident and family education on AROs, hand hygiene, and the purpose of MCP when in place, including what to expect during outbreaks

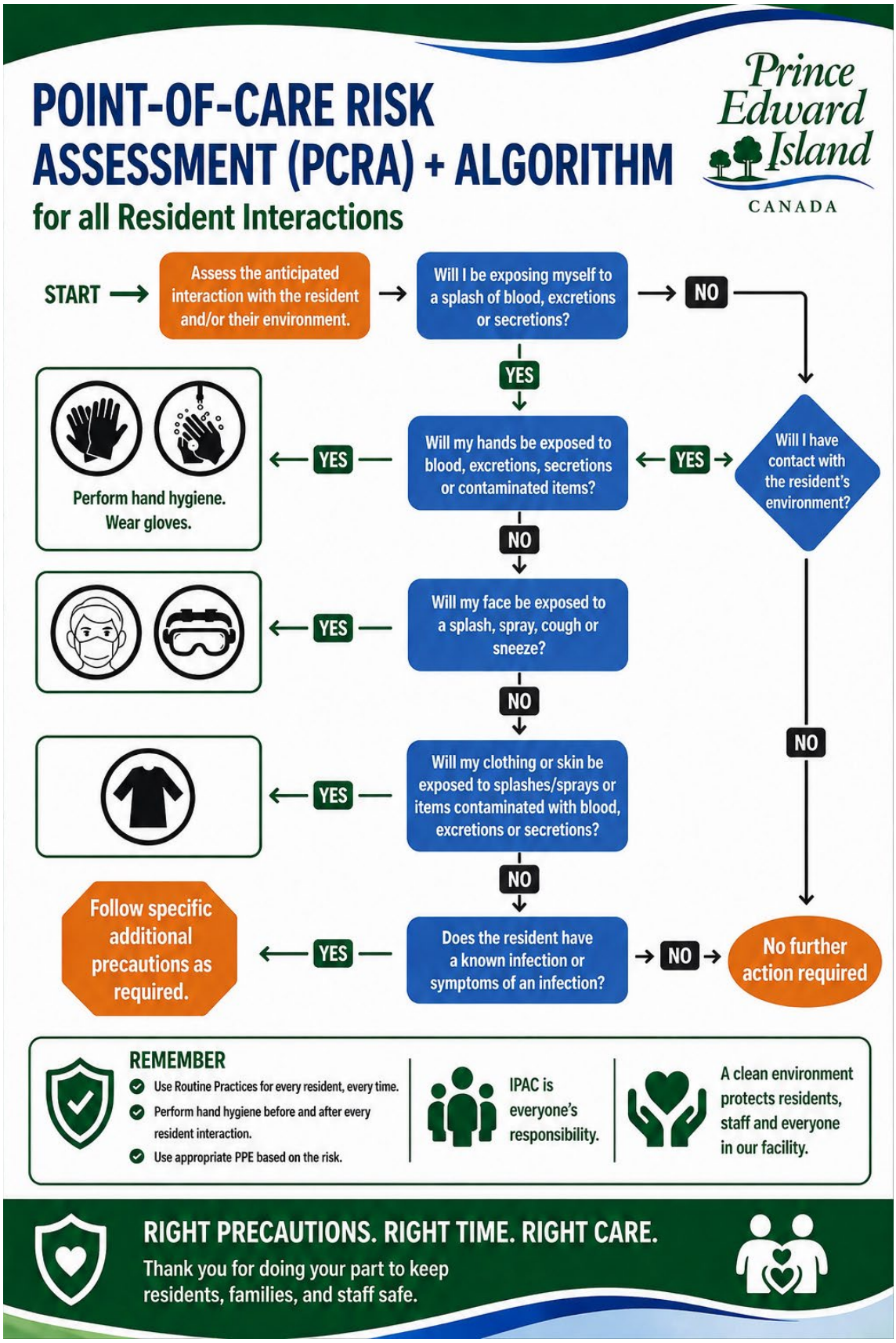
References

1. Legislative Assembly of Prince Edward Island. *Public Health Act Notifiable Diseases and Conditions and Communicable Diseases Regulations.* Charlottetown (PE): Government of Prince Edward Island; 2023 May. Available from: https://www.princeedwardisland.ca/sites/default/files/legislation/p30-1-5-public_health_act_notifiable_diseases_and_conditions_and_communicable_diseases_regulations.pdf
2. Legislative Assembly of Prince Edward Island. *Public Health Act of Prince Edward Island.* Charlottetown (PE): Government of Prince Edward Island; 2022 May. Available from: https://www.princeedwardisland.ca/sites/default/files/legislation/p-30-1-public_health_act.pdf
3. Nova Scotia Health. *Public Health Resources.* Halifax (NS): Nova Scotia Health Authority; n.d.
4. Government of Canada. *Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings.* Ottawa (ON): Public Health Agency of Canada; n.d. Available from: **Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings - Canada.ca**
5. Alberta Health Services. *Management of Antimicrobial Resistant Organisms Across the Continuum of Care.* Edmonton (AB): Alberta Health Services; n.d. Available from: **Management Of Antimicrobial Resistant Organisms Across the Continuum of Care**
6. Government of Newfoundland and Labrador. *Communicable Disease Control Resources.* St. John's (NL): Department of Health and Community Services; n.d.
7. Interior Health Authority. *Infection Prevention and Control Guidelines.* Kelowna (BC): Interior Health; n.d. Available from: https://www.interiorhealth.ca/sites/default/files/PDFS/dc-ipac-antimicrobial-resistant-organisms-aro-resource.pdf
8. Royal Victoria Regional Health Centre. *IPAC Resources.* Barrie (ON): RVH; 2025 March. Available from: https://www.rvh.on.ca/wp-content/uploads/2025/03/Toolkit-for-AROs-RVH-IPAC-Hub-June-2023-Updated.pdf
9. Interior Health Authority. *IPAC Resources.* Kelowna (BC): Interior Health; n.d. Available from: https://interiorhealth.ca
10. IPAC Canada. *Program Standards.* Winnipeg (MB): IPAC Canada; 2024 Dec (revised). Available from: https://ipac-canada.org/wp-content/uploads/2025/03/IPACCanada_ProgramStandards_2024_12_30_revised.pdf
11. Public Health Ontario. *Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes.* Toronto (ON): Public Health Ontario; [date unknown]. **Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes**
12. Alberta Health Services. *Management of ARO Positive Residents in Continuing Care.* Edmonton (AB): Alberta Health Services; n.d. Available from: **Management of ARO Positive Residents in Continuing Care**
13. Public Health Ontario. *Best Practices in IPAC.* Toronto (ON): Public Health Ontario; n.d. Available from: **Best Practices in IPAC | Public Health Ontario**
14. Public Health Agency of Canada. *Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings.* Ottawa (ON): PHAC; n.d. Available from: **Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings**

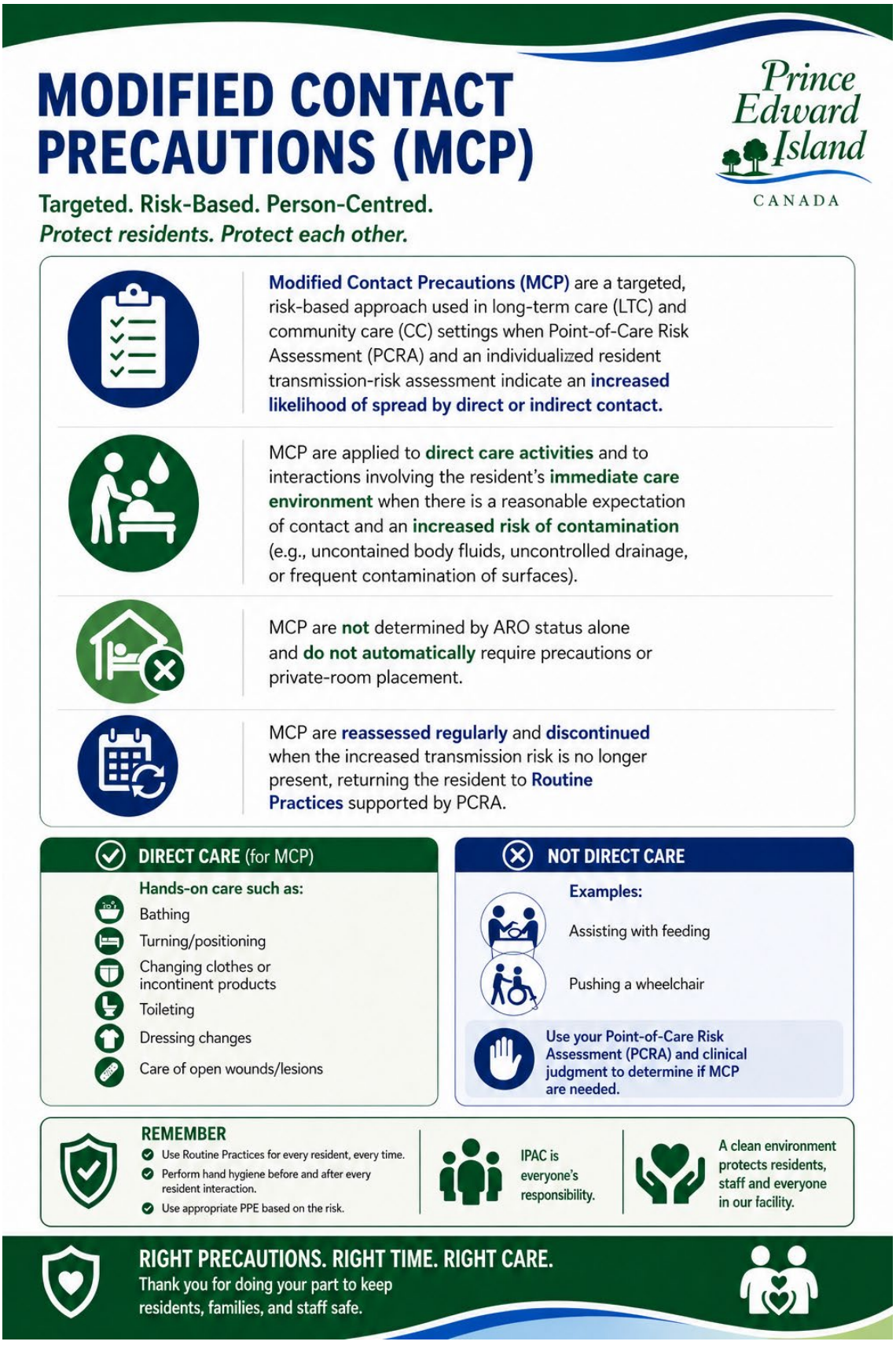
Appendix A: Hand Hygiene



Appendix B: Point-of-Care Risk Assessment (PCRA) + Algorithm for all Resident Interactions



Appendix C: Modified Contact Precautions (MCP)



Appendix D: Resident Risk Assessment for AROs

RESIDENT RISK ASSESSMENT FOR AROs (MRSA, VRE, CPE, *Candida auris*)

Prince Edward Island
CANADA

RESIDENT INFORMATION

First Name: _____
Last Name: _____
Date of Birth (yyyy-mm-dd): _____
Medical Record Number (MRN): _____

ASSESSOR INFORMATION

First Name: _____
Last Name: _____
Position: _____
Date (yyyy-mm-dd): _____

Routine Practices and Point-of-Care Risk Assessment (PCRA) are the foundation of care for all residents, including those known to be ARO-positive.

A "Yes" response **does not automatically** require Modified Contact Precautions (MCP) and must be interpreted in conjunction with the Risk of Transmission Assessment (see Appendix F, Table 1).

RISK-BASED ASSESSMENT FOR ARO TRANSMISSION

Risk Factor	Yes	No
History of MRSA colonization or infection	☐	☐
History of VRE colonization or infection	☐	☐
History of CPE or other multidrug-resistant organism (MDRO)	☐	☐
Presence of wounds, ulcers, psoriasis (if open/active), or invasive devices (e.g., urinary catheter, vascular access device, feeding tube)	☐	☐
Immunocompromised (e.g., cancer chemotherapy, transplant, biologic or high-dose steroid therapy)	☐	☐
Health care exposure outside Canada	☐	☐
Exposure to a unit or setting with a known ARO outbreak	☐	☐

IF ALL RESPONSES = NO

Continue Routine Practices and PCRA

No MCP required

Private room placement is determined based on assessed transmission risk and resident needs, not ARO status alone.

IF ANY RESPONSE = YES

Perform an individualized Risk of Transmission assessment (Appendix F, Table 1).

Implement MCP only if transmission risk is increased, such as:
- Uncontrolled drainage or secretions
- Inability to maintain personal hygiene
- Frequent or uncontained incontinence
- Cognitive or behavioural challenges affecting infection control practices

Ensure dedicated equipment and supplies if Modified Contact Precautions are required.

Consider screening cultures only if clinically indicated, in consultation with IPAC.

Notify the IPAC team for guidance as needed.

DOCUMENTATION AND COMMUNICATION

Document assessment findings and required precautions in the resident's health record and plan of care.

Communicate risk status and precautions to:
- Nursing and interprofessional care team
- Environmental and support services

Reassess and update precautions as the resident's condition or risk factors change.

Clear communication supports safe, consistent care for every resident.

RIGHT PRECAUTIONS. RIGHT TIME. RIGHT CARE.

Thank you for doing your part to keep residents, families, and staff safe.

Appendix E: Specimen Collection

Appendix F1: Technical Reference / Management of ARO-Positive Residents

Cross-link to poster: This technical appendix supports the visual quick reference poster, Appendix F: Management of ARO-Positive Residents. The poster is intended for point-of-care use. This appendix provides detailed guidance for clinical decision-making, audit, and policy reference.

Purpose

- Provide standardized, risk-based guidance for the management of residents identified with antimicrobial-resistant organisms (AROs) in LTC and CC settings.
- Support safe care while preserving resident dignity, autonomy, participation, and quality of life.

Core Principles

Risk-based, not organism-based	Routine Practices and PCRA apply to all residents.
Targeted use of MCP	MCP are applied for direct care when PCRA and resident transmission risk indicate increased risk of transmission.
Resident-centred and proportionate	Care approaches should balance infection prevention with quality of life and be reassessed regularly.

Risk of Transmission and Placement

Risk Level	Clinical Indicators	Precautions	Placement Guidance
Lower risk	Able to perform or accept hand hygiene; secretions, excretions, and wound drainage are contained; no uncontrolled drainage.	Routine Practices + PCRA. MCP is not required based on ARO status alone.	Private room is not required based on ARO status alone. Room sharing may be appropriate when risk is low.
Higher risk	Uncontrolled wound drainage or secretions; inability to maintain personal hygiene; frequent incontinence not contained by products; cognitive or behavioural factors affecting containment.	Routine Practices + MCP are applied for direct care when PCRA and resident transmission risk indicate increased risk of transmission.	Private room is recommended when risk cannot be mitigated. Cohorting may be considered based on IPAC guidance.

Resident Participation in Activities

Risk Level	Participation	Additional Measures
Lower risk	No restriction from activities solely due to ARO status.	Support hand hygiene as needed. Ensure affected areas are covered or contained when applicable.
Higher risk	Participation is conditional and based on current risk assessment.	Restrict participation only when transmission risk cannot be reasonably mitigated. Reassess regularly.

Accommodation and Room Sharing

Scenario	Guidance
Private room	Use is based on risk of transmission, not ARO status alone. Consider resident preference, clinical needs, roommate vulnerability, and ability to contain secretions or excretions.
Shared room	Permitted when risk is low and care needs can be safely managed. If applicable, residents with the same organism may share a room when clinically appropriate.
Key consideration	Ensure secretions, excretions, and wound drainage are contained. Reassess if the resident condition changes.

Precautions and Care Practices

Element	Requirement
Routine Practices	Apply to all residents, for all care, at all times.
PCRA	Complete before each interaction to determine anticipated exposure and required controls.
MCP	Apply for direct care when PCRA and resident risk indicate increased risk of transmission.
PPE	Select according to anticipated exposure to blood, body fluids, secretions, excretions, contaminated items, or environmental contamination.
Signage and communication	Follow organizational and IPAC guidance where signage or additional communication is required.

Environment and Equipment

Area	Standard
Shared equipment	Clean and disinfect between residents and between uses according to manufacturer instructions and organizational procedures.
Non-cleanable items	Do not share items that cannot be cleaned and disinfected, such as some books, electronics, or personal items.
Environmental cleaning	Follow routine cleaning protocols. Increase attention to high-touch surfaces and shared areas when risk is increased.
Supplies and storage	Store clean supplies to prevent contamination. Avoid bringing excess supplies into the resident care area.

Acute Care vs. LTC and CC Context

Context	Guidance
Acute care practices	Practices such as strict precautions or prolonged room restriction are generally not appropriate for LTC and CC unless specifically indicated.
LTC and CC focus	Use Routine Practices and PCRA, targeted MCP when indicated, and interventions that preserve dignity, autonomy, and quality of life.

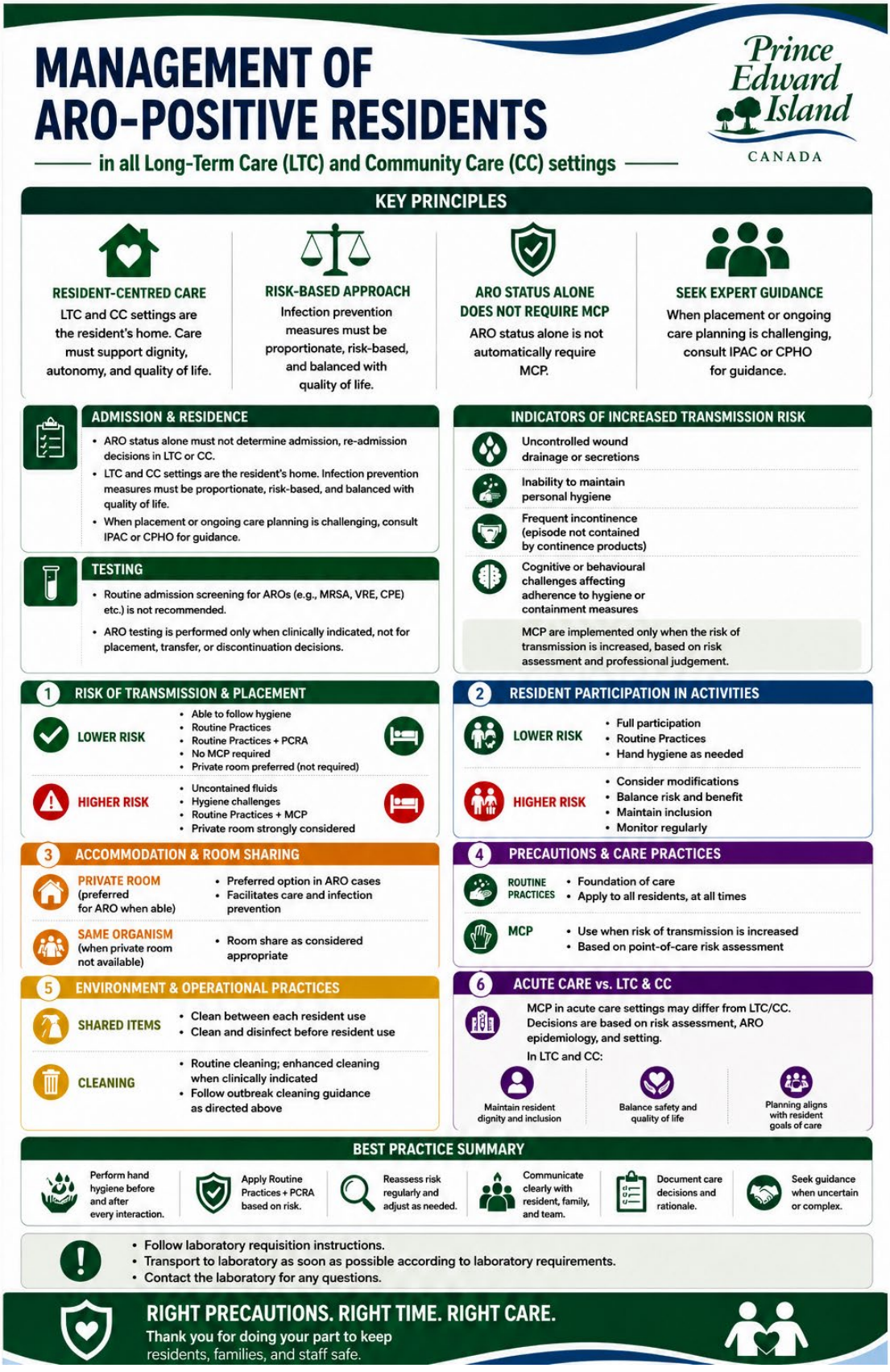
Documentation and Care Planning Requirements

- Document ARO status and current transmission risk in the resident record according to organizational process.
- Document precautions and any additional measures clearly in the plan of care.
- Reassess risk regularly and when the resident condition, hygiene, wound drainage, continence, or behaviour changes.
- Communicate required precautions to relevant staff while maintaining resident privacy and dignity.

Consultation

- Consult IPAC or CPHO when risk assessment is unclear, placement decisions are complex, or ongoing transmission concerns exist.

Appendix F2: Quick Reference Poster / Management of ARO-Positive Residents



Appendix G1: Technical Reference / ARO Outbreak Management in LTC and CC

Cross-link to poster: This technical appendix supports the visual quick reference poster, Appendix G: ARO Outbreak Management. The poster is intended for point-of-care use. This appendix provides detailed guidance for outbreak management, audit, and policy reference.

Purpose

- Provide standardized, risk-based guidance for the management of ARO outbreaks in LTC and CC
- Support safe care while preserving resident dignity, autonomy, participation, and quality of life.

Core Principles

Risk-based, not organism-based	Outbreak response is guided by transmission risk, not organism alone
Routine Practices and PCRA	Apply to all residents at all times
Targeted use of MCP	MCP are applied for direct care when PCRA and resident transmission risk indicated increased risk of transmission
Resident-centered and proportionate	Balance infection prevention with quality of life; reassess regularly
Least restrictive approach	Avoid unnecessary restrictions whenever possible
Consultation	Consult IPAC or CPHO as needed

Outbreak Triggers

Trigger Indicator	What This Means	Required Actions
≥2 linked cases	Possible transmission	Initiate outbreak response
Increase above baseline	Unusual rise	Notify CPHO and engage IPAC
High-risk organism	Increased concern	Begin enhanced surveillance

Immediate Response

Category	Guidance	Details
Infection Prevention	Routine Practices + PCRA	Implement MCP; signage if indicated
Placement & Cohorting	Based on risk	Private room; cohort residents/staff
Environment	Enhance cleaning	High-touch surfaces; shared equipment
Surveillance	Initiate monitoring	Line list; active case finding

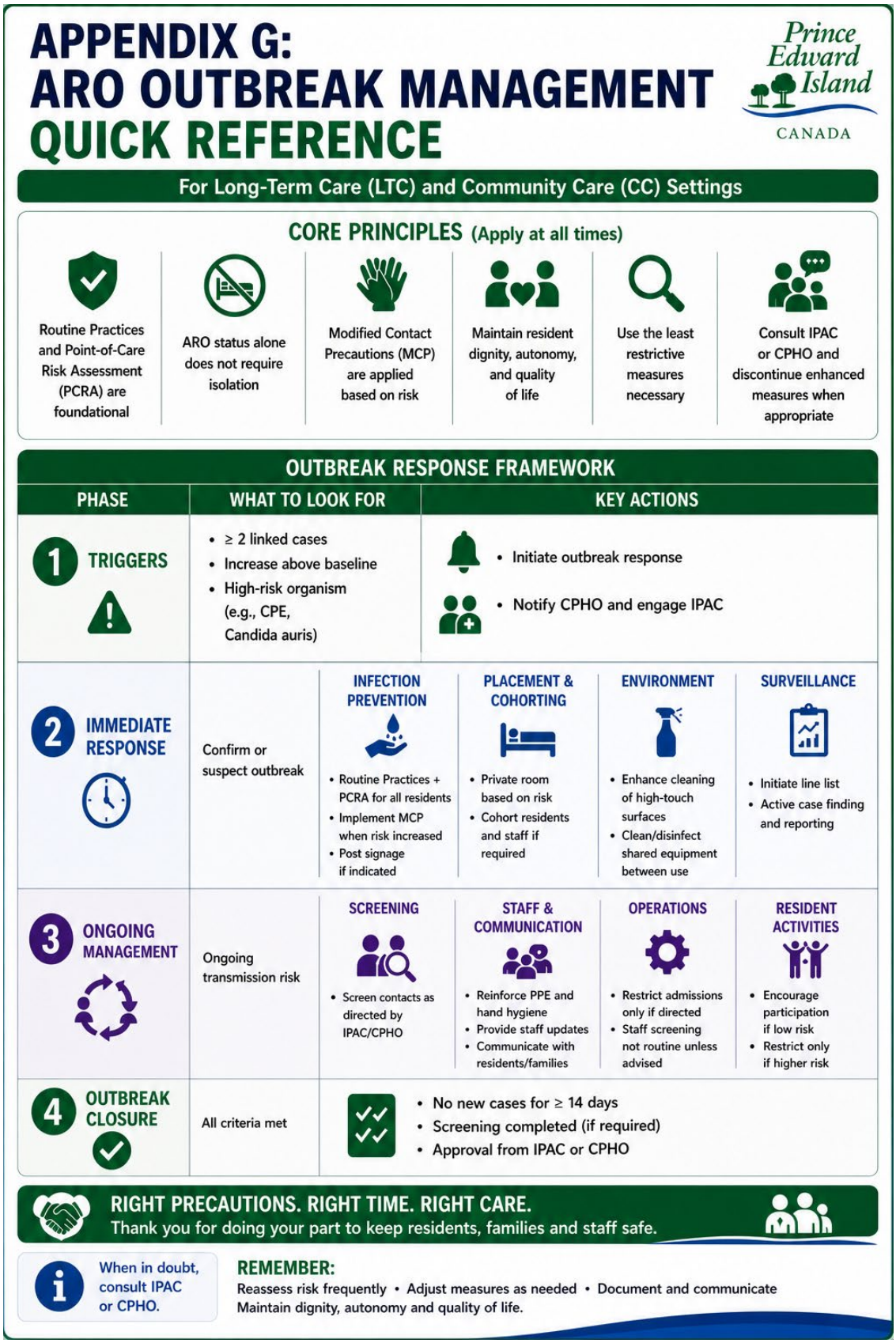
Ongoing Management

Category	Guidance	Details
Screening	Risk-based	Screen contacts per IPAC/CPHO
Staff & Communication	Ongoing	Reinforce PPE; communicate
Operations	Maintain care	Restrict admissions if directed
Resident Activities	Risk-based	Encourage low risk; restrict higher risk

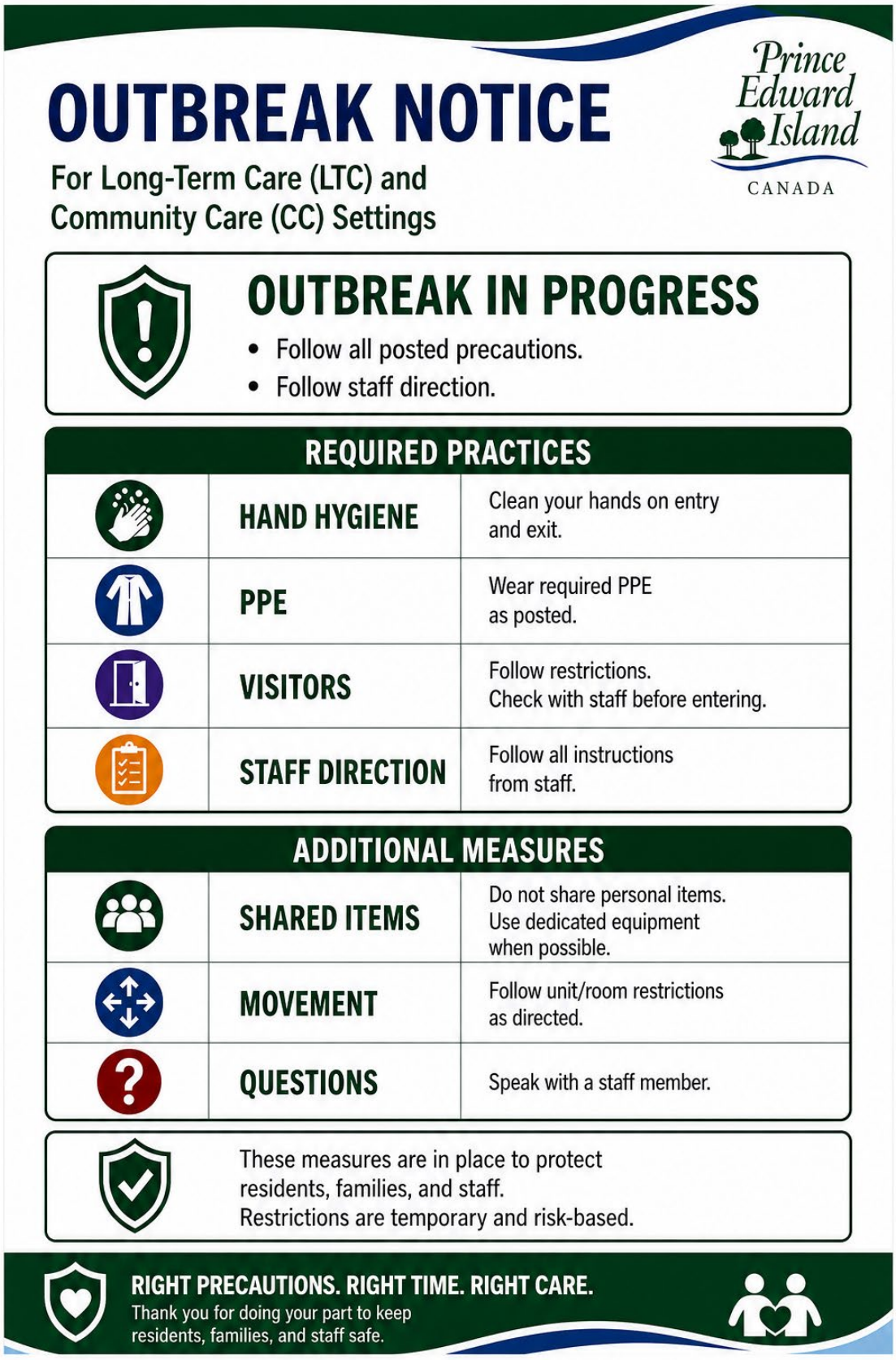
Outbreak Closure

Criteria	Requirements
No new cases	≥14 days
Screening	Completed
Approval	IPAC or CPHO

Appendix G2: Quick Reference Poster / ARO Outbreak Management



Appendix H: Outbreak Signage



Appendix I: ARO Line List

Appendix I: ARO Line List ARO OUTBREAK LINE LIST TRACKING TOOL										
• Record all residents screened or identified • Update in real time • Maintain Confidentiality • Use with PCRA and Routine Practices										
Resident Name / MRN /	**Unit / Room**	**ARO Type**	**Swab (Y/N)**	**Date**	**Result**	**Site**	**Symptoms**	**Risk Factors**	**Status**	**Notes**