Acute Care & Outpatient Settings Webinar Series

March 12, 2025

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

NE ICAP

NEBRASKA INFECTION CONTROL ASSESSMENT AND PROMOTION PROGRAM

Presenters & Panelists & Moderator

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Moderator today:

Margaret Deacy	mdeacy@nebraskamed.com

Questions & Answer Session

- Please use the Q&A box in the webinar platform to type a question to be read aloud.
  - If your question is not answered during the webinar, please call (402) 552-2881 Monday – Friday 8:00 am – 4:00 pm CST to speak with one of our Infection Preventionists or e-mail your question to nebraskaicap@nebraskamed.com

Slides & Webinar Recordings Available

- During this webinar, slides are available on the NE ICAP Acute Care webpage
- Visit the NE ICAP Past Webinars and Slides webpage
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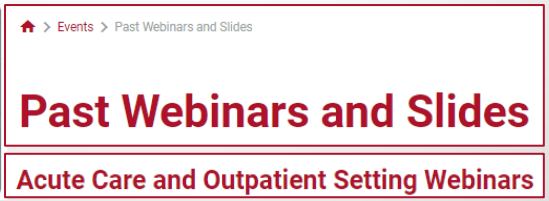


Continuing Education Disclosures

- 1.0 Nursing Contact Hour is awarded for the LIVE viewing of this webinar
- Nebraska Infection Control Assessment and Promotion Program is approved as a provider of nursing continuing professional development by the Midwest Multistate Division, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- To obtain nursing contact hours, you must attend the entire live activity and complete the post-course survey form.
- No relevant financial relationships were identified for any member of the planning committee or any presenter/author of the program content.

Respiratory Season Update

Juan Teran, MD

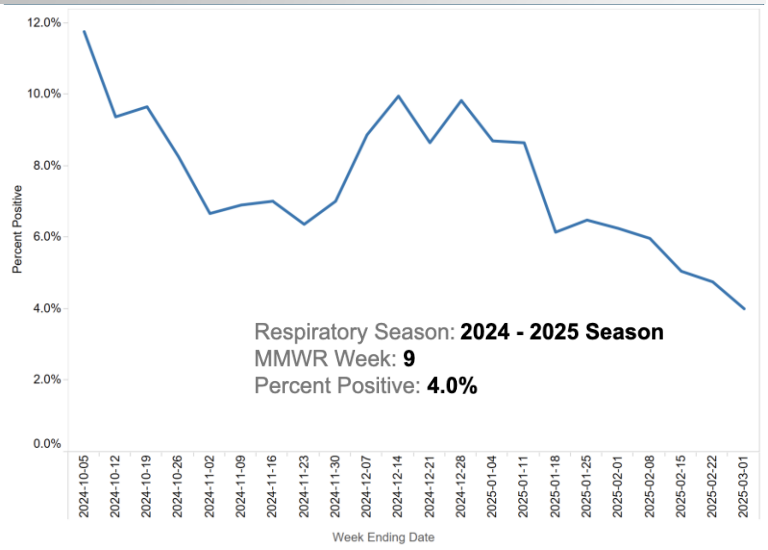
Medical Director, NE ICAP

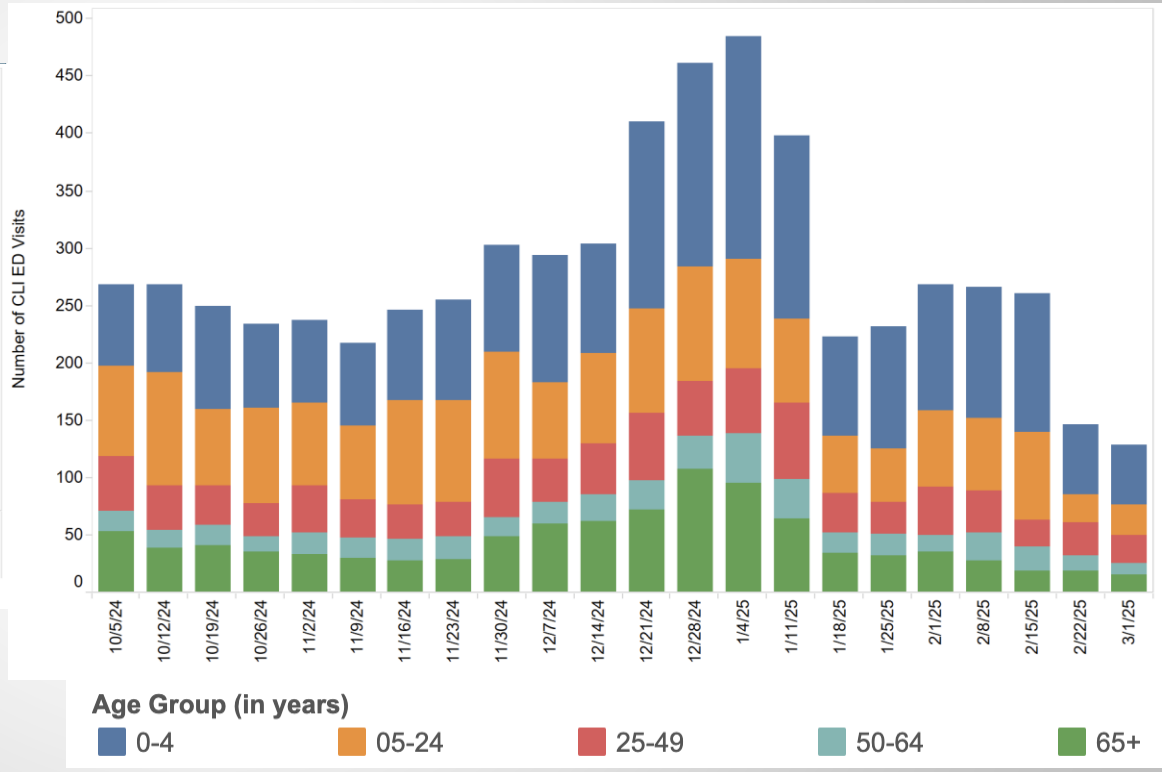
NE ICAP

Key points

- COVID, flu, and RSV activity is decreasing
- Measles cases are increasing nationwide
- There is a rise in tuberculosis cases

NE DHHS COVID Data





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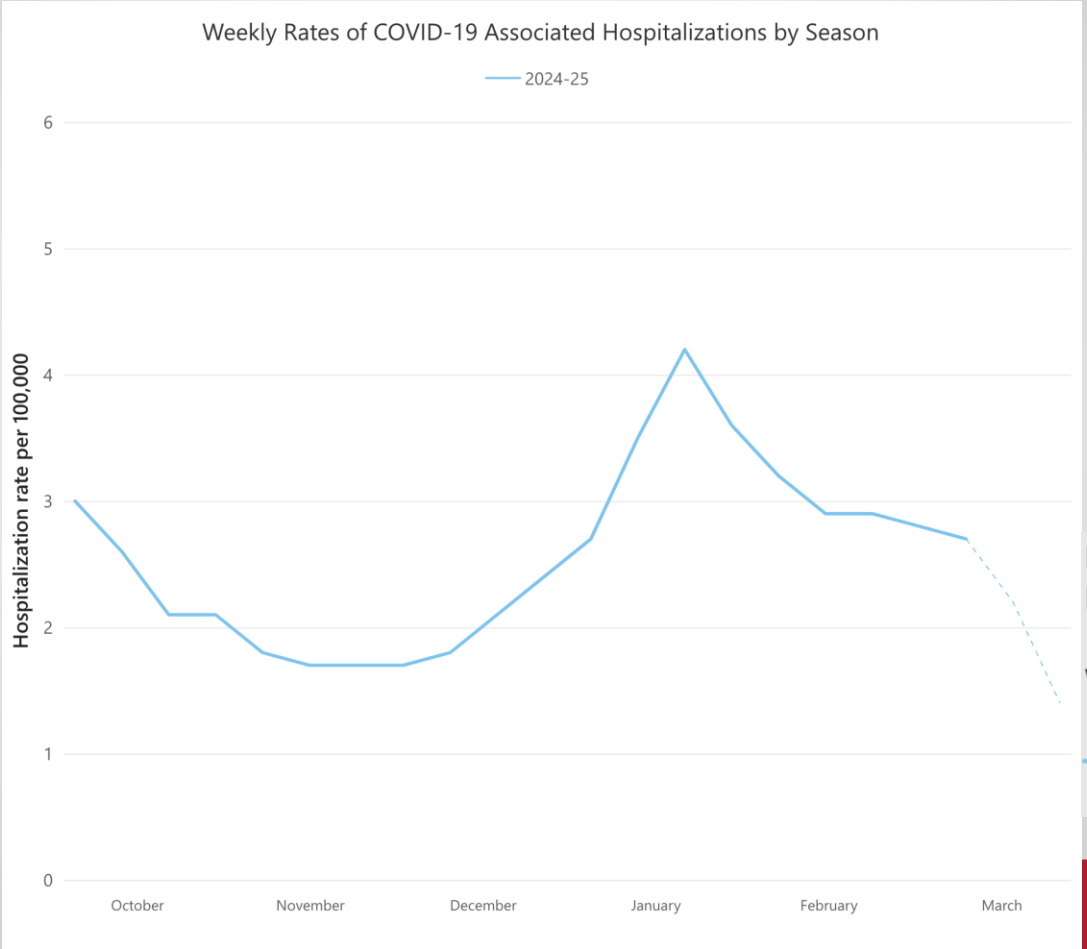
COVID Rate of Hospitalizations US



For **2024-25** season:
MMWR Week **9**

Week End Date **3/1/2025**

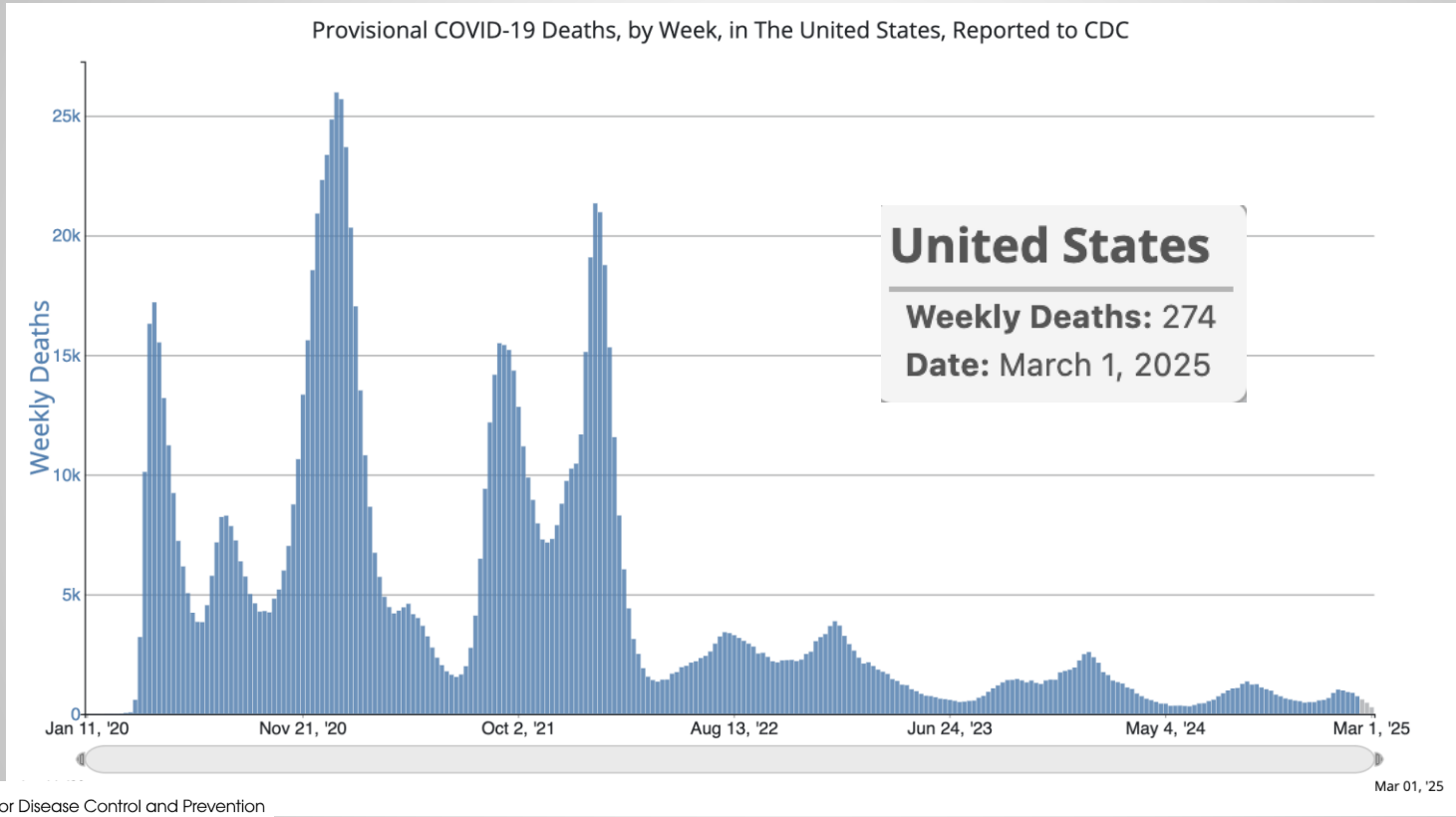
2024-25 1.4

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

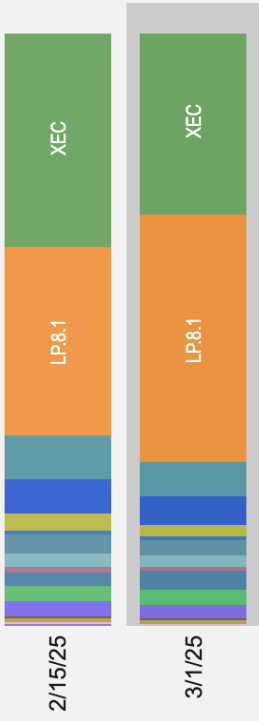
COVID Data Tracker

NE ICAP

COVID Deaths



Nowcast:** Model-based projected estimates of variant proportions



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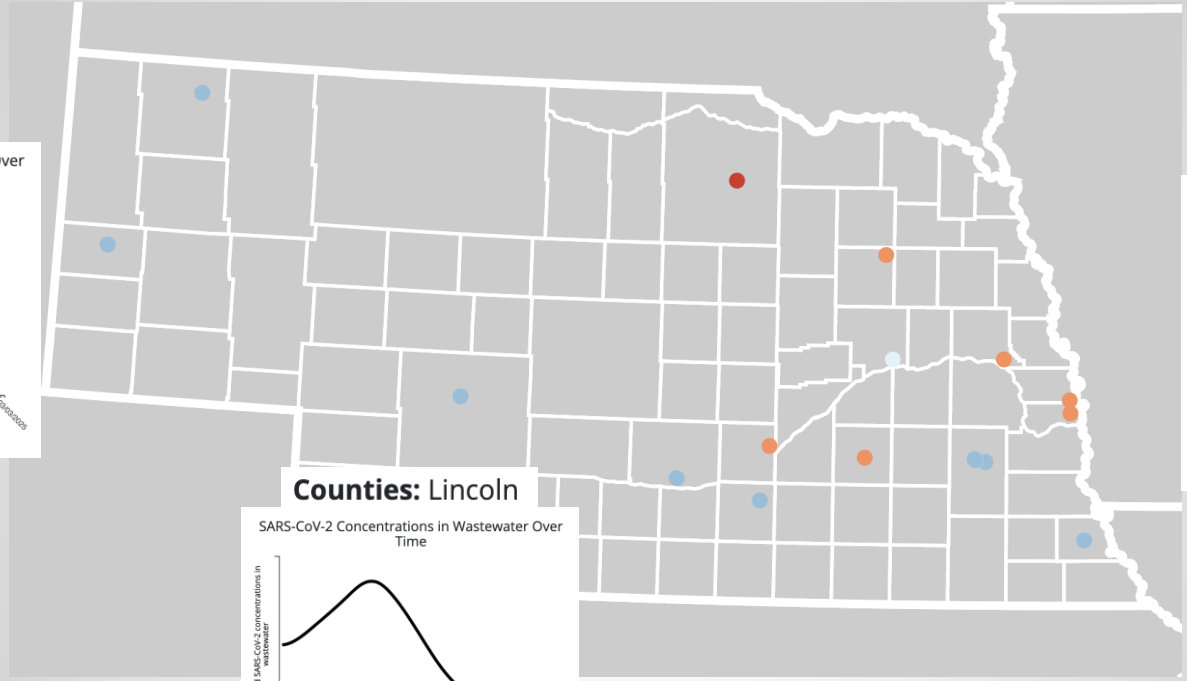
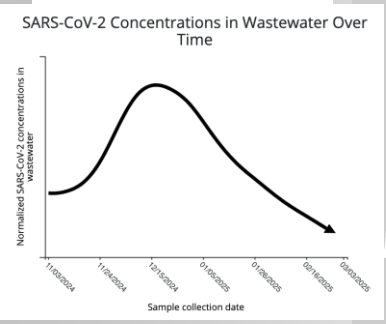
COVID Data Tracker

NE ICAP

COVID Waste-water activity

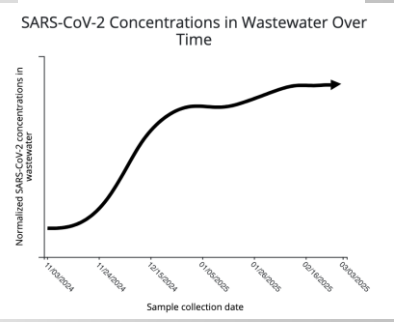


Counties: Scotts Bluff



Counties: Lincoln

Counties: Douglas, Sarpy



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COVID Data Tracker

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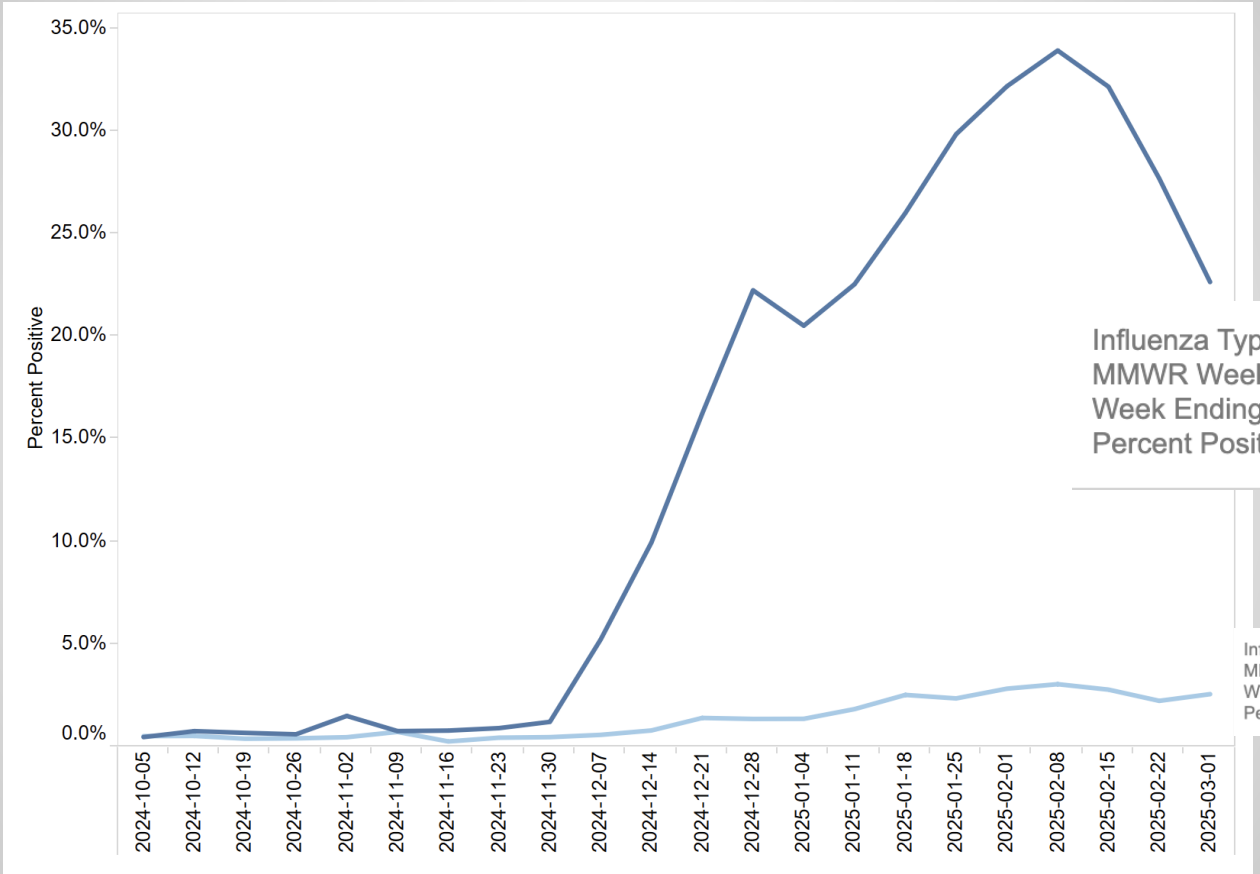
Influenza NE DHHS report



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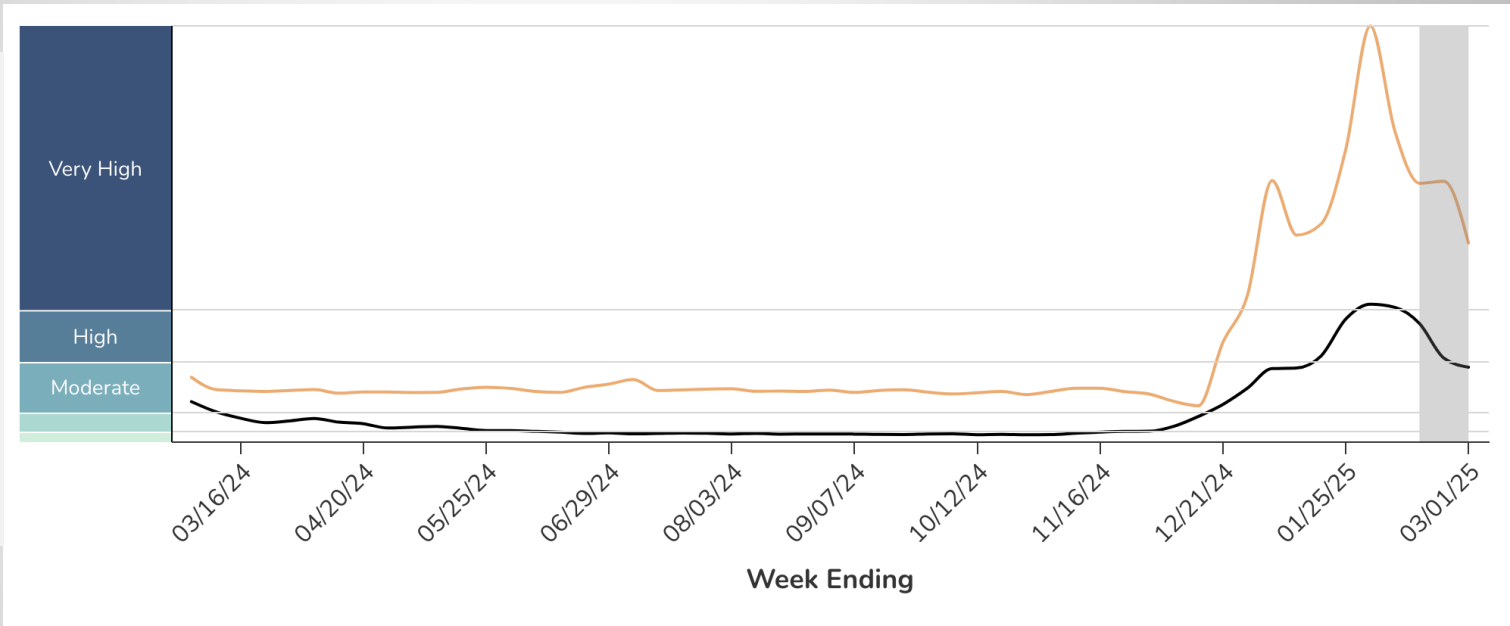
Influenza Wastewater Activity

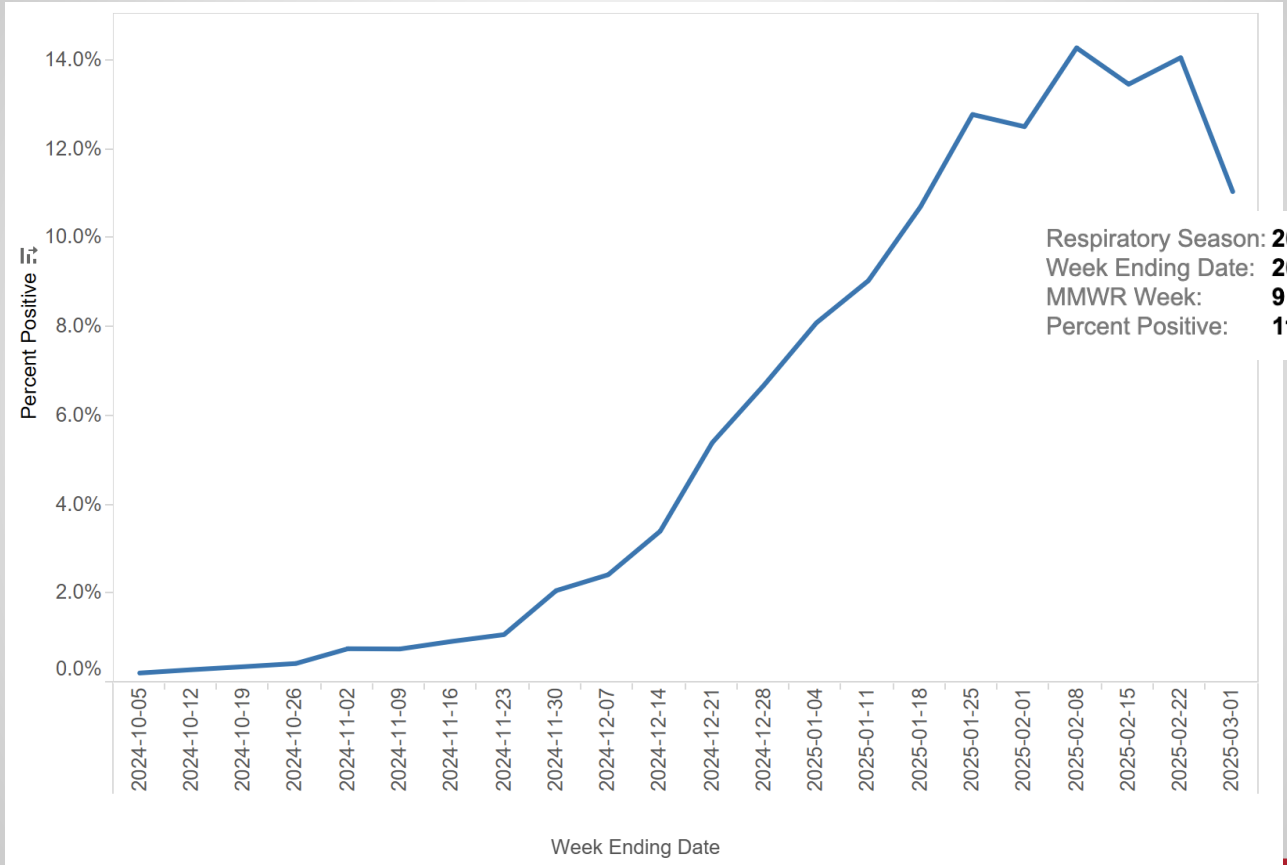
In Nebraska, the wastewater viral activity level for influenza A is currently **Very High.**

Sites reporting in the last week: 16
Sites reporting in the last 30 days: 16

VERY HIGH



RSV



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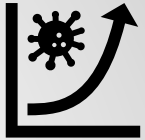
Increase in Measles Cases & Outbreaks

Nebraska Department of Health and Human Services

Health Alert Network

ADVISORY

Increase in Global and Domestic Measles Cases and Outbreaks: Ensure Children in the United States and Those Traveling Internationally Six Months and Older are Current on MMR Vaccination



Measles is serious and can be fatal.

Get vaccinated if not up to date and see travel recommendations

CDC Measles Vaccination

Summary

Texas is currently experiencing a measles outbreak in Gaines County and surrounding counties. As of March 4, 2025, Texas has 159 cases, including one pediatric death. There are also measles cases in New Mexico, Kentucky, New Jersey, and Pennsylvania. Nebraska does not currently have any cases. Most cases reported in 2025 have been among children aged 12 months and older who had not received the measles-mumps-rubella (MMR) vaccine. Many countries, including travel destinations such as Thailand, India, and Indonesia, are also experiencing measles outbreaks. To prevent measles infection and reduce the risk of community transmission from importation, all U.S. residents traveling internationally, regardless of destination, should be current on their MMR vaccinations. Healthcare providers should ensure children are current on routine immunizations, including MMR. Given the currently high population immunity against measles in most U.S. communities, the risk of widescale spread is low. However, pockets of low coverage leave some communities at higher risk for outbreaks.

Increase in Global and Domestic Measles Cases and Outbreaks 2025.03.07

Measles is an acute respiratory viral illness

- **Initial Symptoms**
  - Fever (may spike to more than 104° F)
  - Malaise (overall feeling of illness and discomfort)
  - Cough
  - Coryza (runny nose)
  - Conjunctivitis (red watery eyes)

} the 3 "C"s

  - 2 – 3 days after symptoms begin: Koplik's spots
  - 3 – 5 days after symptoms begin: Maculopapular rash
    - Usually appears 14 days after exposure
    - Spreads from head to trunk to lower extremities
      - It usually begins as flat red spots that appear on the face at the hairline.
      - Spreads downward to the neck, trunk, arms, legs, and feet.
      - Small raised bumps may also appear on top of the flat red spots.

Clinical Overview of Measles | CDC About Measles | CDC Measles Symptoms and Complications

2 – 3 days after symptoms begin, Koplik's spots can appear

Koplik's spots are tiny white macular (flat) spots that may appear inside the mouth including hard and soft palate – especially opposite lower premolars.

This was a patient who presented with Koplik's spots on palate due to pre-eruptive measles on day three of the illness.
Source: CDC/PHIL

This patient presented on the third pre-eruptive day with "Koplik spots" indicative of the beginning onset of measles.
Source: CDC/PHIL

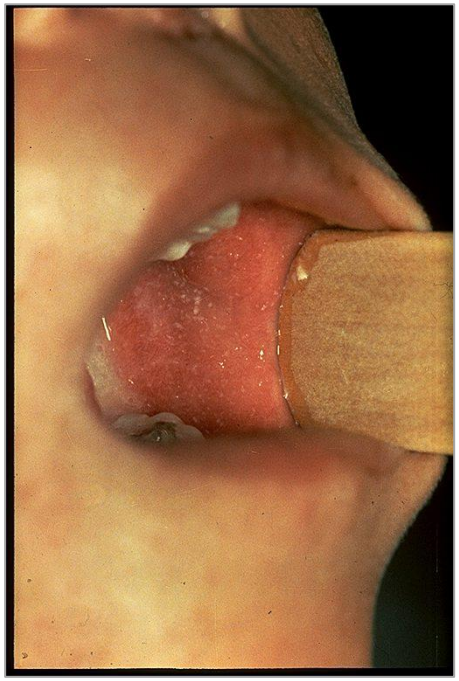


Photo Courtesy of vaccineinformation.org

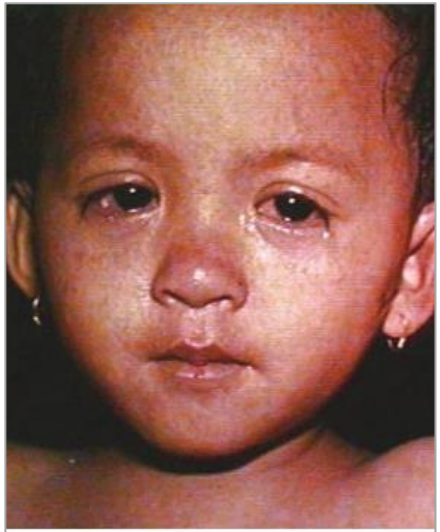
CDC Photos of Measles

3 – 5 days after symptoms begin: Maculopapular rash appears

Maculopapular rash usually appears 14 days after exposure

- Spreads from head to trunk to lower extremities
- It usually begins as flat red spots that appear on the face at the hairline.
- Spreads downward to the neck, trunk, arms, legs, and feet.
- Small raised bumps may also appear on top of the flat red spots.

Young child with moderate illness: runny nose, teary eyes caused by measles infection.
Source: "Measles Clinical Features" video

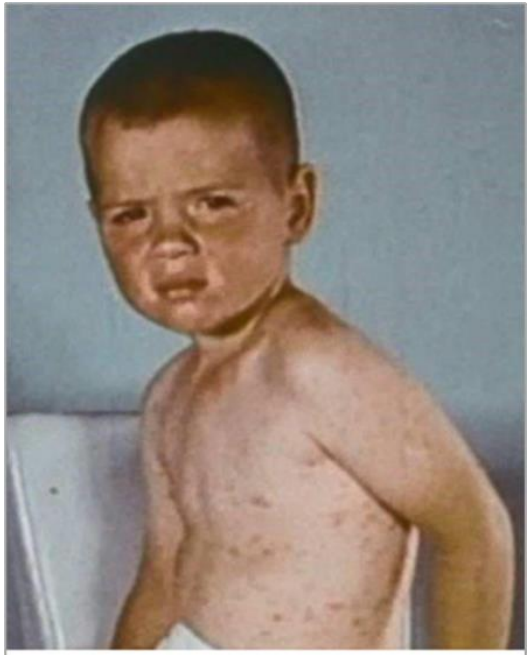


Eyes of a child with measles
Source: CDC/PHIL

Young, dark-skinned child with watery eyes, runny nose, and raised rash.
Source: "Measles Clinical Features" video

CDC Photos of Measles

Photos of Measles Skin Rashes



Young boy five to six days into illness with rash and cough.

Source: "Measles Clinical Features" video

Face of boy after three days with measles rash.

Source: CDC/PHIL

CDC Photos of Measles

Child with a classic measles rash after four days.

Source: CDC/PHIL

Incubation period

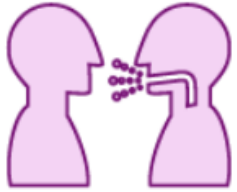
- 7 to 21 days with an average of 11 to 12 days to symptom onset and 14 days to rash onset

Infectious period

- 4 days before through 4 days after rash appearance

Transmission

- Airborne spread when an infectious person coughs, sneezes, or breathes
- Measles remains infectious in the air for up to two hours after an infected person leaves an area
- Direct contact with infectious droplets



It spreads when an infected person coughs or sneezes.

Clinical Overview of Measles

Isolate Immediately

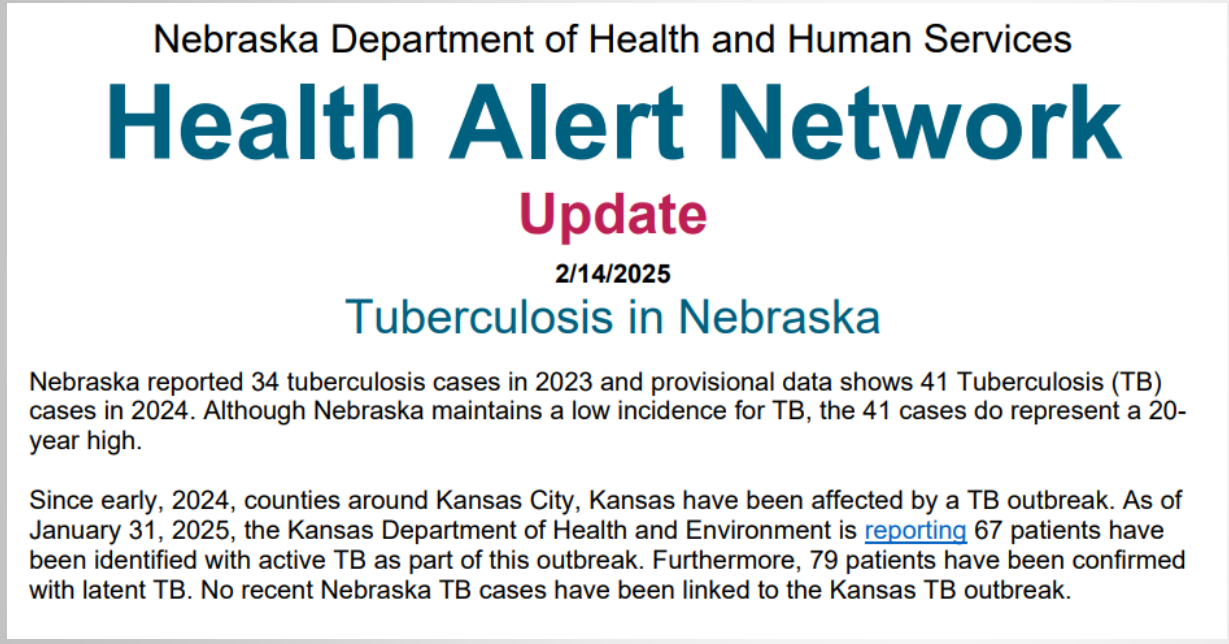
- Do not allow patients with suspected measles to remain in the waiting room or other common areas! Isolate patients with suspected measles immediately, ideally in a single-patient airborne infection isolation room (AIIR) if available, or in a private room with a closed door until an AIIR is available. Healthcare providers should be adequately protected against measles and should adhere to standard and airborne precautions when evaluating suspect cases, regardless of their vaccination status.

Increase in Global and Domestic Measles Cases and Outbreaks 2025.03.07

NE ICAP Clinic Guidance for Suspected Measles Cases

The virus can live for up to two hours in an airspace.

Update on Tuberculosis in Nebraska



Nebraska Department of Health and Human Services

Health Alert Network

Update

2/14/2025

Tuberculosis in Nebraska

Nebraska reported 34 tuberculosis cases in 2023 and provisional data shows 41 Tuberculosis (TB) cases in 2024. Although Nebraska maintains a low incidence for TB, the 41 cases do represent a 20-year high.

Since early, 2024, counties around Kansas City, Kansas have been affected by a TB outbreak. As of January 31, 2025, the Kansas Department of Health and Environment is reporting 67 patients have been identified with active TB as part of this outbreak. Furthermore, 79 patients have been confirmed with latent TB. No recent Nebraska TB cases have been linked to the Kansas TB outbreak.

- Consider active TB disease as a possible diagnosis for people who have symptoms consistent with TB disease.
- Asymptomatic people who reports exposure to someone with TB or are at higher risk for TB (either because of their exposure risks or weakened immune system due to certain medications or health conditions) should be evaluated for latent TB.
- Treatment for patients with Latent TB is strongly encouraged to prevent the development of active TB disease.

NE DHHS HAN Update - TB in Nebraska 2024.02.14

Questions & Answer Session

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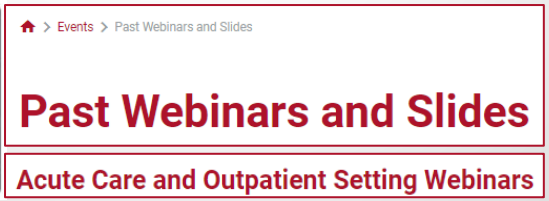


Antimicrobial Prophylaxis for Surgical Site Infections (SSI)

Josh Lechner, PharmD, MT (ASCP)CM
PGY-2 Infectious Diseases Pharmacy Resident
Nebraska Medicine

University of Nebraska Medical Center

Link to recorded presentation:

https://echo360.org/media/e26fa574-6be9-4825-bee2-78900e727298/public

University of Nebraska Medical Center

Objectives

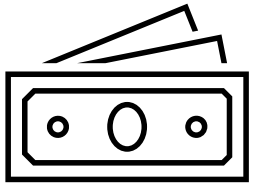

Recall patient, surgical, and environmental risk factors for SSI
Describe antimicrobial prophylaxis selection, administration, and appropriate re-timing intervals
Identify key auditing targets in SSI

Background

- **Surgical site infection** – infection following an operation at an incision site or adjacent to the surgical incision

0.5% to 3% of patients experience SSI

Patients remain hospitalized 7 to 11 days longer than patients without SSI

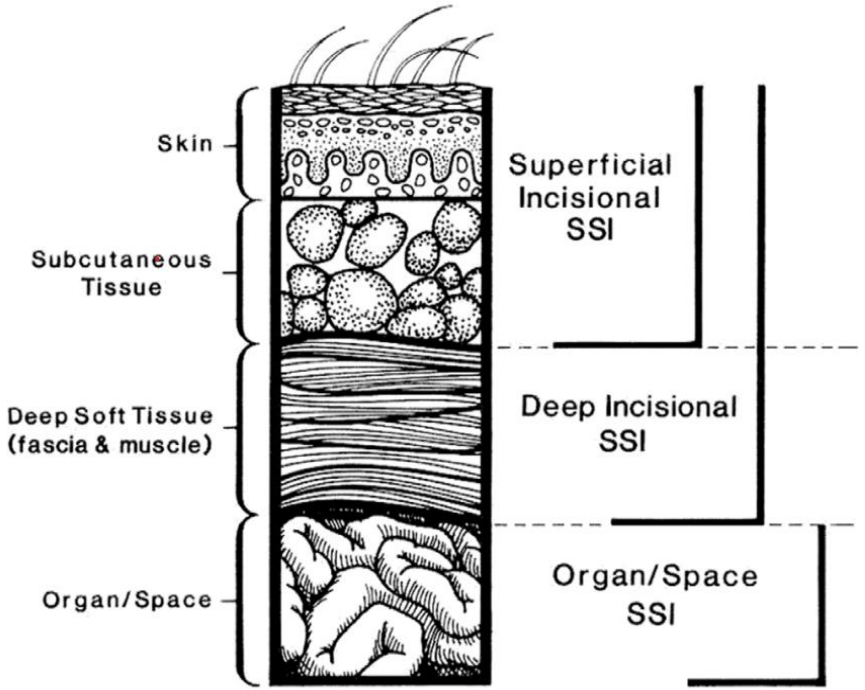


Estimated $3 to $10 billion in US healthcare costs

Background

NHSN definitions

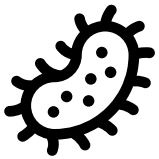
- Superficial incision (skin or subcutaneous)
- Deep incisional (involving fascia and/or muscular layers)
- Organ-space – any body part opened or manipulated during procedure excluding skin, fascia or muscle layers



Background

Onset

- Within 30 – 90 days
- Often diagnosed within 14 days from procedure



Pathogens

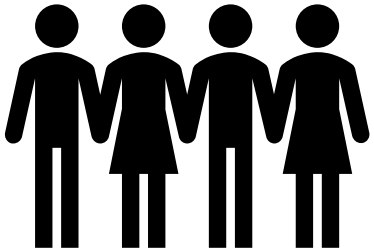
- *Staphylococcus aureus* (MSSA & MRSA)
- *Escherichia coli*
- *Enterococcus spp*
- Coagulase negative staphylococci
- Polymicrobial

Procedures with higher incidence of SSI

- Colon/small bowel
- Craniotomy
- Breast
- Open fracture reduction

Patient Risk Factors

- Age
- Obesity
- *S. aureus* colonization

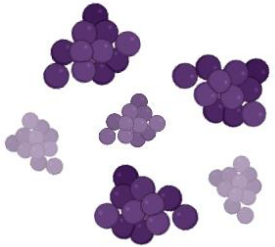


- Smoking
- Diabetes, especially uncontrolled
- Immunosuppressed patients
- Malnutrition

Surgical Risk Factors

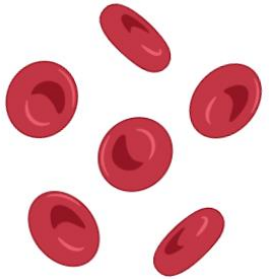
- Inadequate surgical scrub

- Antiseptic preparation of skin



- Antimicrobial prophylaxis

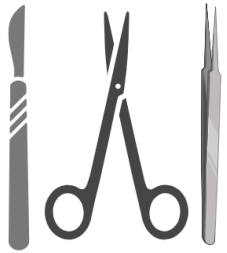
- Surgery duration



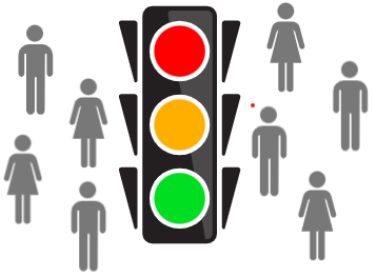
- Blood transfusion

Environmental Risk Factors

- Environmental surfaces



- Surgical Equipment Sterilization



- Operating Room Traffic

- Ventilation

SSI Prevention

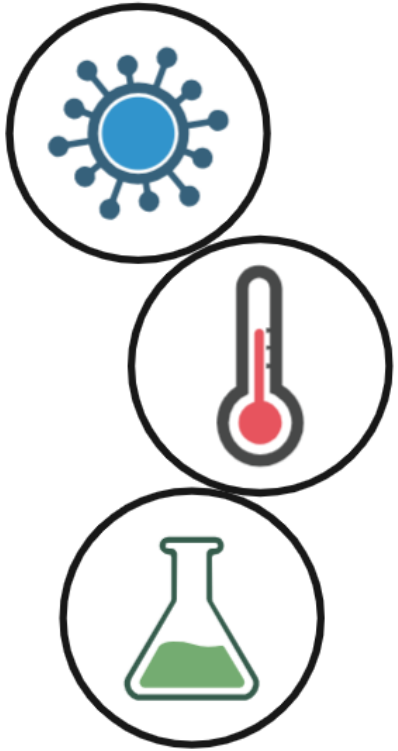
- **Glucose control**
  - Control for all surgical patients including without diabetes
  - Goal <150 mg/dL
  - Delayed wound healing
- **Smoking cessation**
- ***S. aureus* colonization**

SSI Prevention

- **Decolonization** – reduce or eliminate certain types of bacteria, specifically *Staphylococcus aureus*
  - Especially in cardiothoracic and orthopedic procedures or procedures involving hardware
  - Decreases risk of surgical site infections
- Intranasal mupirocin and chlorhexidine bathing
  - Mupirocin twice daily, chlorhexidine once daily up to 5 days
- Can consider povidone-iodine immediately before surgery

SSI Prevention

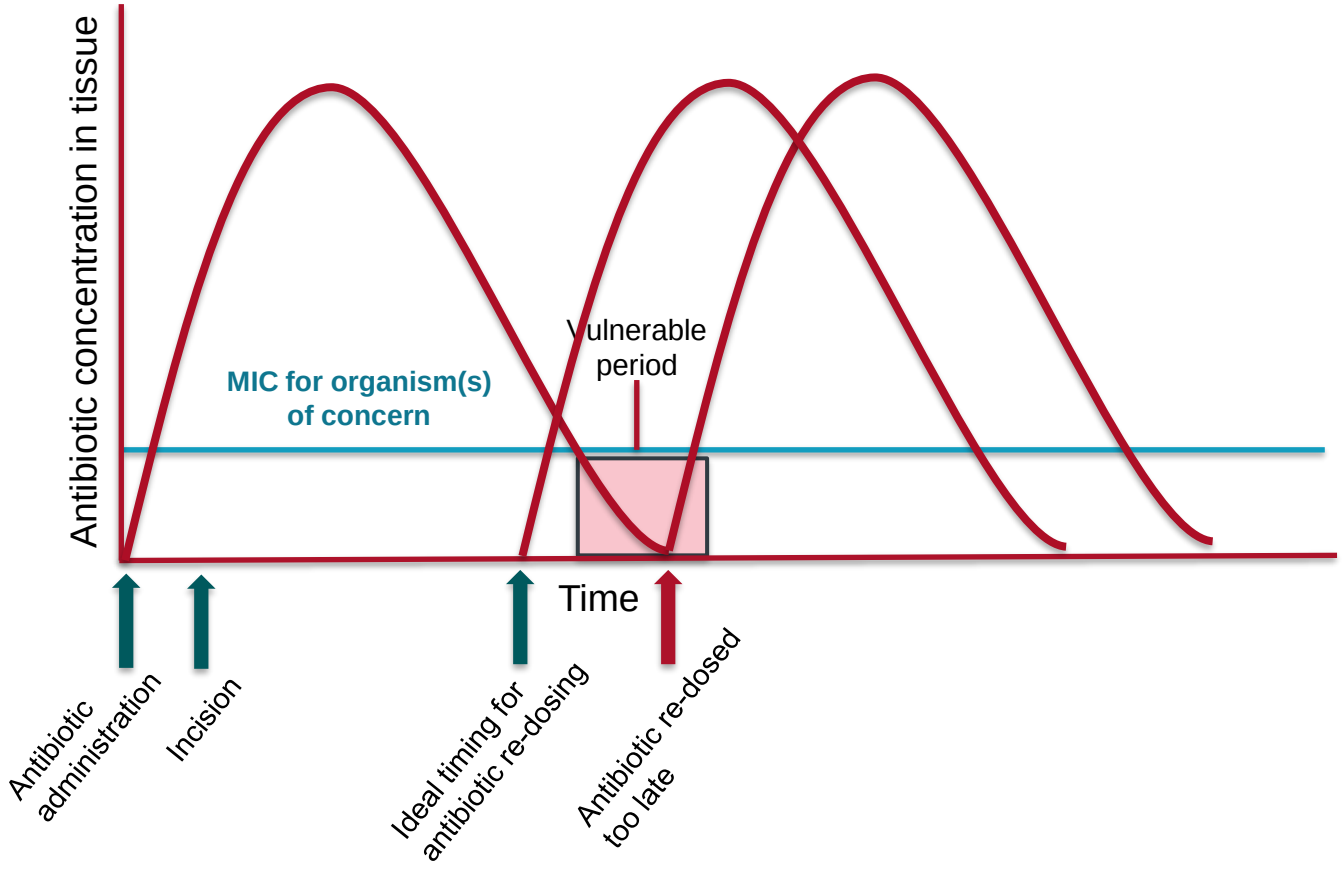
- **Shaving hair**
  - Avoid, if possible
  - Use clippers, if necessary (avoid razors)
- **Use alcohol-containing skin agents combined with antiseptic**
  - Chlorhexidine gluconate with alcohol
- **Maintain normothermia when possible**



Antimicrobial Prophylaxis

- **Administer within 1 hour prior to incision to maximize tissue concentration**
  - Goal is to ensure serum and tissue concentrations above MIC for likely organisms to cause SSI
- **If using vancomycin or fluoroquinolone (levofloxacin or ciprofloxacin) administer within 2 hours prior to incision**
  - Vancomycin usually infused over 1-1.5 hours
  - Fluoroquinolones infused over 1 hour

Antimicrobial Prophylaxis



Antimicrobial Prophylaxis

When should the patient be re-dosed?

2 **Half lives of drug have elapsed**

Large volume blood loss
(>1.5L/1,500 mL)

Measure time to re-dose from the time the pre-op antibiotic was administered (not the time the procedure started)

Antimicrobial Prophylaxis

- Redosing of common antimicrobials

Antimicrobial	Half-life* (h)	Redosing Interval*
Cefazolin	**1.2-2.5**	**4 hours**
Cefuroxime	1-2	4 hours
Cefoxitin	0.5-1.1	2 hours
Piperacillin/tazobactam	0.7-1.2	2 hours
Clindamycin	2-4	6 hours
Metronidazole	6-8	8 hours
Levofloxacin	6-8	n/a
Vancomycin	4-6	n/a

*With normal renal function

Antimicrobial Prophylaxis

0745

Pre-operative cefazolin

0830

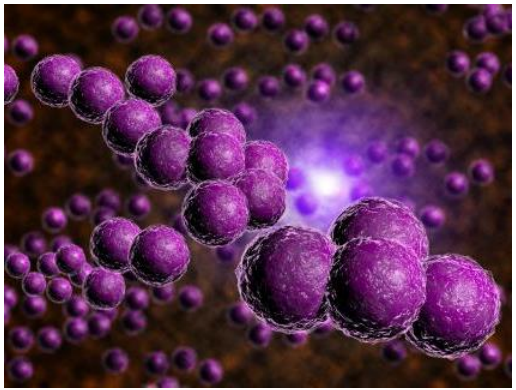
Procedure starts

1145

Next dose cefazolin due

Antimicrobial Prophylaxis - MRSA

Not recommended to routinely use vancomycin



- Consider if MRSA colonized
- Strongly consider especially if surgery involves prosthetic material
  - At Nebraska Medicine – cardiac pacemaker, valve replacement, LVAD, joint replacement, craniotomy, spinal hardware placement

Beta Lactam Allergies

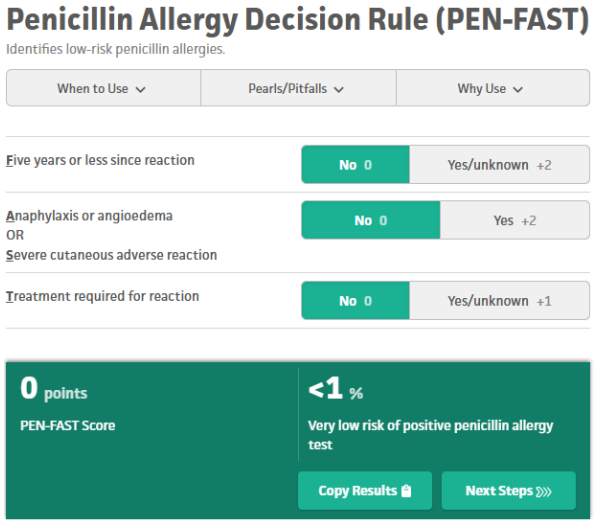
- Cephalosporins are commonly used for surgical antimicrobial prophylaxis
- Cross reactivity between cephalosporins and penicillins is rare
  - Not usually class effect
  - More common if similar side chain

☆ **Cefazolin does not share similar side chain to any other beta-lactam and can be safely given**

– If severe IgE mediated reaction (anaphylaxis) avoid beta lactam class that caused allergy

Beta Lactam Allergies

- Pre-operative assessment
  - PEN-FAST tool
- Nebraska Med Study
  - Penicillin allergy suppressed in patients prescribed cephalosporins where cefazolin is preferred SSI prophylaxis
  - 25% increase in cefazolin use
  - 1 of 175 patients had allergic reaction to cefazolin requiring intervention
  - Fewer patients developed AKI



Antimicrobial Prophylaxis

What if the patient is already on antibiotics?

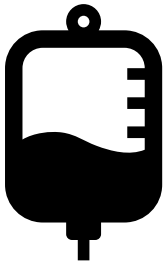
- Surgical antimicrobial prophylaxis should still be given within one hour of incision (or two hours if vancomycin or fluoroquinolone)
- Continue treatment antibiotics at regularly scheduled interval

Antimicrobial Prophylaxis

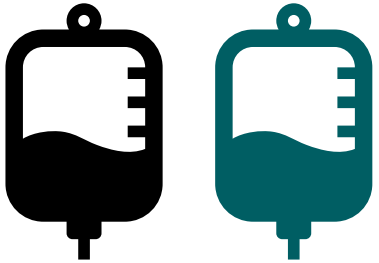
How long should antibiotics continue?

- Discontinue after incisional closure in operating room
  - No evidence antimicrobials given after incisional closure results in reduced SSI except in rare circumstances
- Patient may need treatment antibiotics post-procedure
  - Pus, abscess, phlegmon, osteomyelitis
- Some benefit to continue oral antibiotics for high-risk patients after joint replacement up to 7 days

Cefazolin + Vancomycin



- Add vancomycin if history of MRSA colonization



- Cefazolin provides better coverage of MSSA, other gram-positive organisms, and select gram-negative organisms

General Surgery Prophylaxis

- **Cefazolin 2g once 1 hour prior to procedure**
  - 3g if body weight >120 kg

- Severe beta lactam allergy: Vancomycin 15 mg/kg within 2 hours of procedure

Known MRSA Colonization

- If implanting hardware or prosthetic device: cefazolin 2g once 1 hour prior to procedure PLUS vancomycin 15 mg/kg within 2 hours of procedure

Hysterectomy Prophylaxis

- **Cefazolin 2g once 1 hour prior to procedure**
  - 3g if body weight >120 kg

- Severe beta lactam allergy: clindamycin 900 mg IV + levofloxacin 750 mg IV once

Colorectal Surgery Prophylaxis

- **Cefoxitin 2g IV once 1 hour prior to procedure**

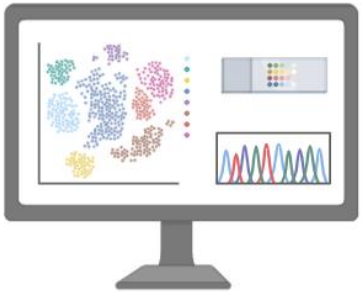
  -or-

- **Cefazolin 2g IV once + Metronidazole 500 mg IV 1 hour prior to procedure**

- Severe beta lactam allergy: Levofloxacin 500 mg IV once + Metronidazole 500 mg IV once

ASP in Surgical Prophylaxis

Standardize order sets

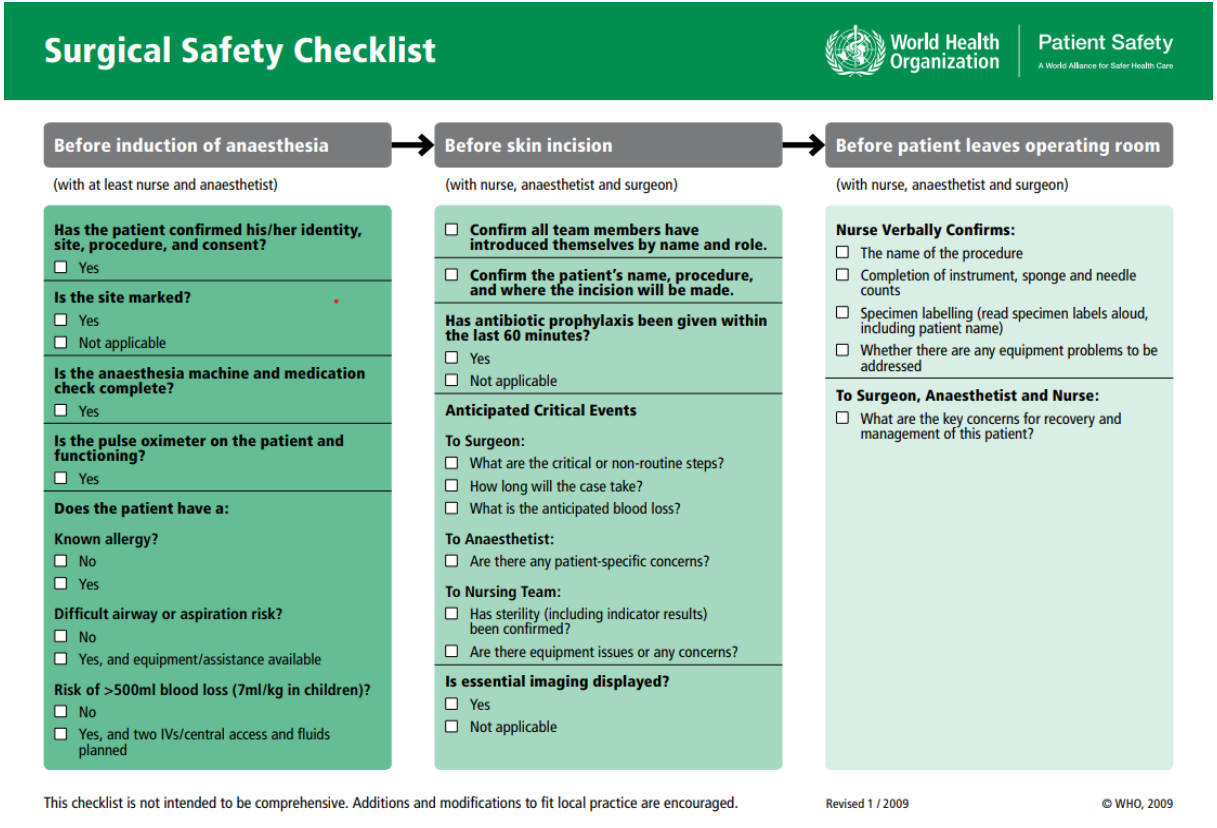


Intra-operative EHR flags for antibiotic re-administration

Default auto-stop surgical prophylaxis or one time dose only

Best Practice

- Surgical safety checklist/bundles to reduce SSI
- Ensure best practice occurs with each surgery



Surgical Safety Checklist

World Health Organization | Patient Safety
A World Alliance for Safer Health Care

Before induction of anaesthesia
(with at least nurse and anaesthetist)

Has the patient confirmed his/her identity, site, procedure, and consent?
- ☐ Yes

Is the site marked?
- ☐ Yes
- ☐ Not applicable

Is the anaesthesia machine and medication check complete?
- ☐ Yes

Is the pulse oximeter on the patient and functioning?
- ☐ Yes

Does the patient have a:

Known allergy?
- ☐ No
- ☐ Yes

Difficult airway or aspiration risk?
- ☐ No
- ☐ Yes, and equipment/assistance available

Risk of >500ml blood loss (7ml/kg in children)?
- ☐ No
- ☐ Yes, and two IVs/central access and fluids planned

Before skin incision
(with nurse, anaesthetist and surgeon)

- ☐ **Confirm all team members have introduced themselves by name and role.**
- ☐ **Confirm the patient's name, procedure, and where the incision will be made.**

Has antibiotic prophylaxis been given within the last 60 minutes?
- ☐ Yes
- ☐ Not applicable

Anticipated Critical Events

To Surgeon:
- ☐ What are the critical or non-routine steps?
- ☐ How long will the case take?
- ☐ What is the anticipated blood loss?

To Anaesthetist:
- ☐ Are there any patient-specific concerns?

To Nursing Team:
- ☐ Has sterility (including indicator results) been confirmed?
- ☐ Are there equipment issues or any concerns?

Is essential imaging displayed?
- ☐ Yes
- ☐ Not applicable

Before patient leaves operating room
(with nurse, anaesthetist and surgeon)

Nurse Verbally Confirms:
- ☐ The name of the procedure
- ☐ Completion of instrument, sponge and needle counts
- ☐ Specimen labelling (read specimen labels aloud, including patient name)
- ☐ Whether there are any equipment problems to be addressed

To Surgeon, Anaesthetist and Nurse:
- ☐ What are the key concerns for recovery and management of this patient?

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

Revised 1 / 2009

SSI Reporting

Required to be reported to NHSN

1. SSI following colon surgery
2. SSI following abdominal hysterectomy

SSI Trends in Nebraska

- Overall, among **Acute Care Hospitals**, there was a 22% **increase** in colon SSIs between 2022 and 2023
  - 2021 SIR 1.291
  - 2022 SIR 0.918
  - **2023 SIR 1.116**

NHSN Acute Care Hospitals Surgical site infections (SSI) following colon surgery in adults, ≥ 18years						
Year	SIR	ALL US SIR	# of Facilities Reporting	# of Infections	# of Infections Predicted	Rank
2016	1.392	0.933	22	72	52	49
2017	1.142	0.906	21	55	48	41
2018	1.107	0.887	22	58	52	41
2019	1.199	0.855	21	60	50	47
2020	0.931	0.81	22	42	45	38
2021	1.291	0.831	22	72	56	51
2022	0.918	0.858	23	49	53	32
2023	1.116	0.879	22	61	54	43

2022 National and State Healthcare-Associated Infections Progress Report
2023 National and State Healthcare-Associated Infections Progress Report

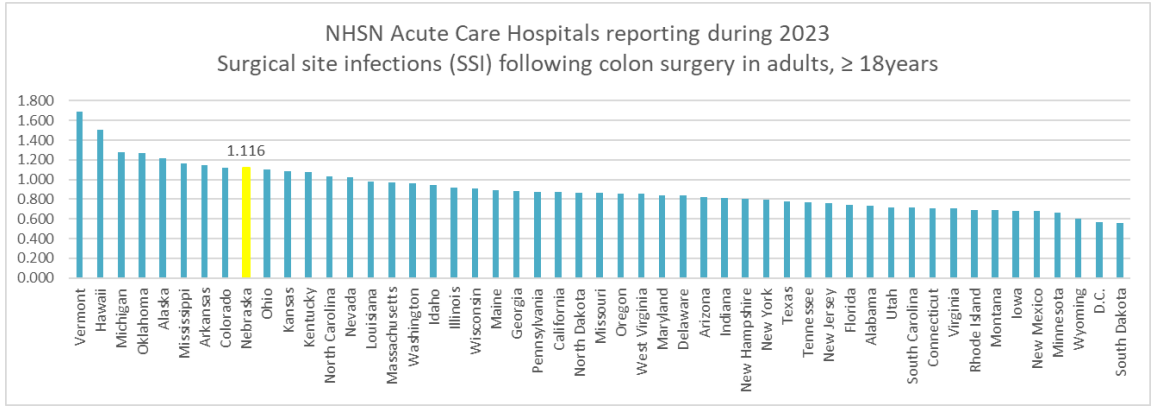
SSI Trends in Nebraska

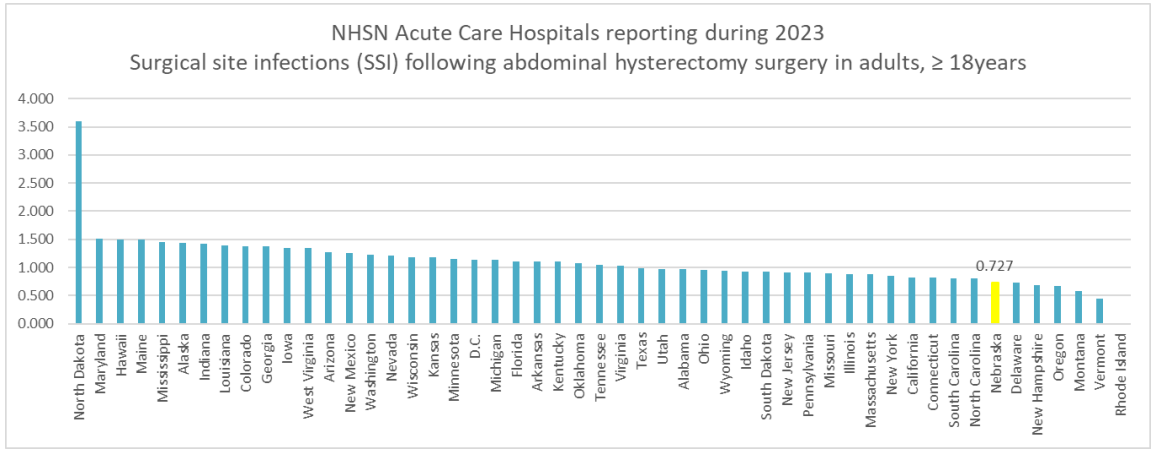
- Overall, among **Acute Care Hospitals**, there was a 44% **decrease** in hysterectomy SSIs between 2022 and 2023
  - 2021 SIR 1.581
  - 2022 SIR 1.299
  - **2023 SIR 0.727**

NHSN Acute Care Hospitals Surgical site infections (SSI) following abdominal hysterectomy surgery in adults, ≥ 18years						
Year	NE SIR	ALL US SIR	# of Facilities Reporting	# of Infections	# of Infections Predicted	National Rank
2016	1.176	0.874	21	15	13	42
2017	1.167	0.89	22	13	11	40
2018	1.001	0.938	22	12	12	33
2019	1.28	0.979	21	18	14	44
2020	1.617	0.892	21	16	10	50
2021	1.581	0.993	22	19	12	48
2022	1.299	0.951	22	15	12	44
2023	0.727	1.031	22	9	12	7

2022 National and State Healthcare-Associated Infections Progress Report
2023 National and State Healthcare-Associated Infections Progress Report

SSI Trends in Nebraska





2022 National and State Healthcare-Associated Infections Progress Report
2023 National and State Healthcare-Associated Infections Progress Report

SSI Survey

- Online survey of Nebraska hospitals conducted by Nebraska HAI/Antimicrobial Resistance Advisory council to assess implementation of evidence-based practice recommendations
- Infection preventionists completed survey in collaboration with perioperative teams regarding surgical protocols

- ✓ Procedural
- ✓ Antimicrobial Prophylaxis
- ✓ Operating Room Design
- ✓ Patient Preparation
- ✓ Auditing

SSI Survey – Antimicrobial Prophylaxis

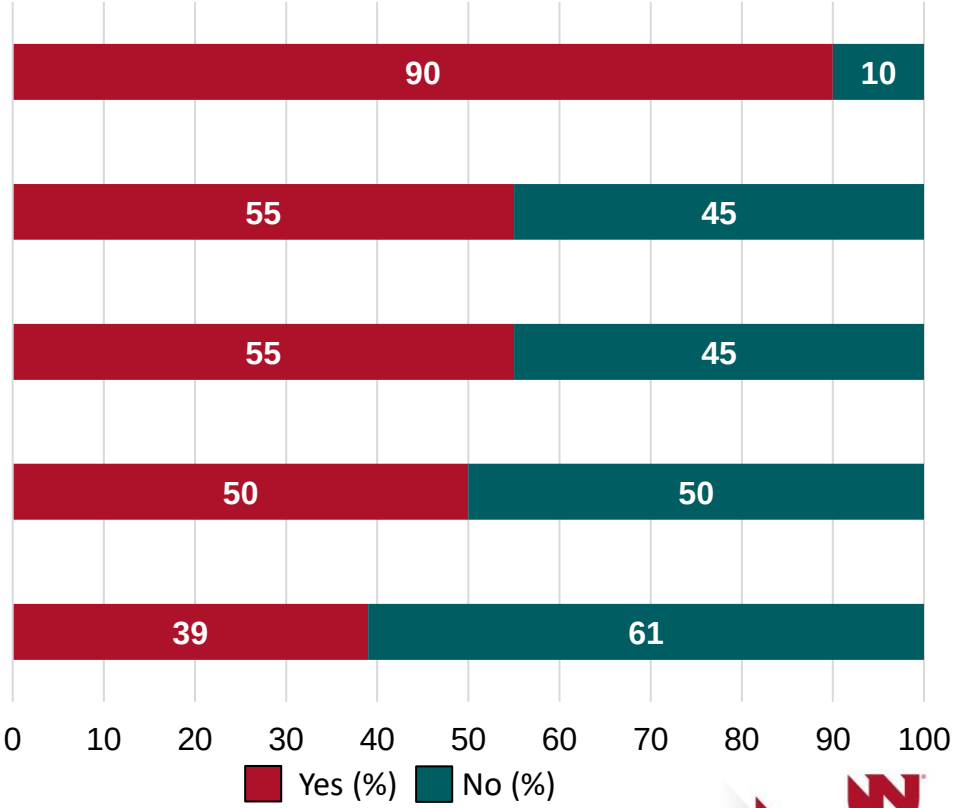
The antibiotic dose is given within 1 hour prior to cut time (unless vancomycin or fluoroquinolone). (n=49)

Antibiotic re-dosing is performed as indicated based on duration of surgical case and blood loss. (n=49)

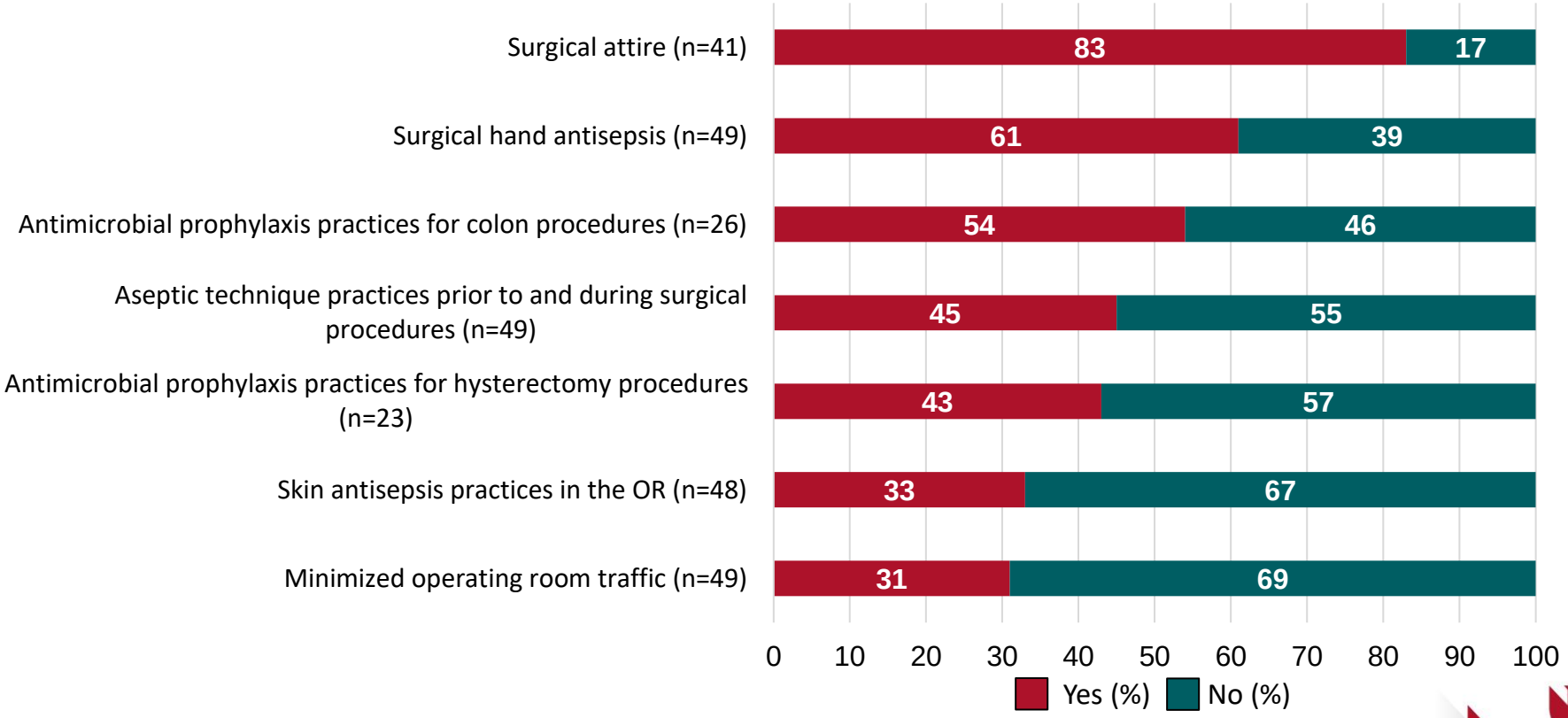
Antibiotic prophylaxis is adjusted for the planned procedure (addition of anaerobic coverage in pelvic cancer or bowel surgery). (n=49)

The facility has protocols for pre- and intraoperative agent selection for colon procedures. (n=26)

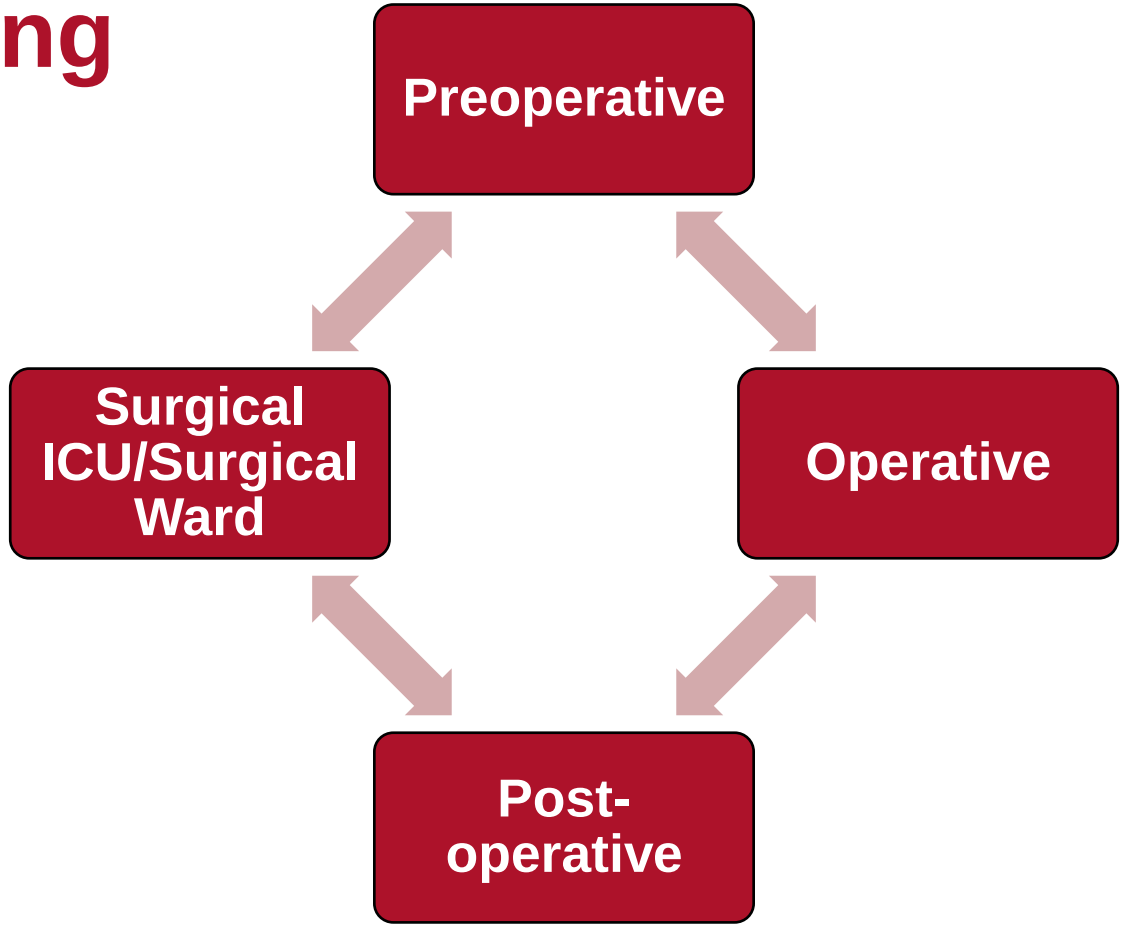
The facility has protocols for pre- and intraoperative agent selection for hysterectomy procedures (abdominal or vaginal). (n=23)



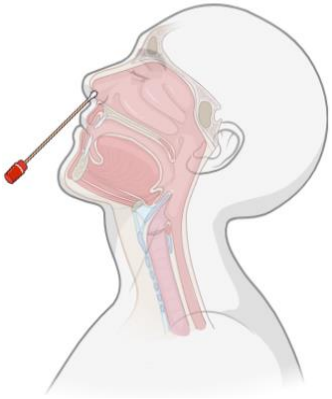
SSI Survey - Auditing



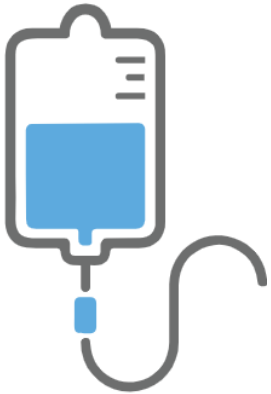
Auditing


Preoperative
Operative
Post-operative
Surgical ICU/Surgical Ward

Auditing – Pre-operative



MRSA decolonization

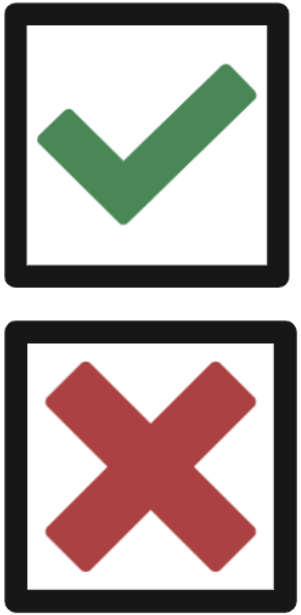


Antimicrobial prophylaxis

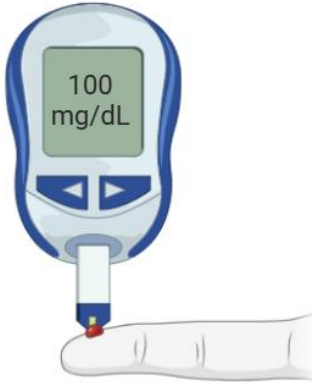
Hand Hygiene

Auditing – Intra-operative

- ❑ Hand hygiene
- ❑ Surgical PPE
- ❑ Aseptic practice throughout procedure
- ❑ Operating Room traffic
- ❑ Operating Room environmental factors
- ❑ Antimicrobial prophylaxis re-administration



Auditing – Post-operative

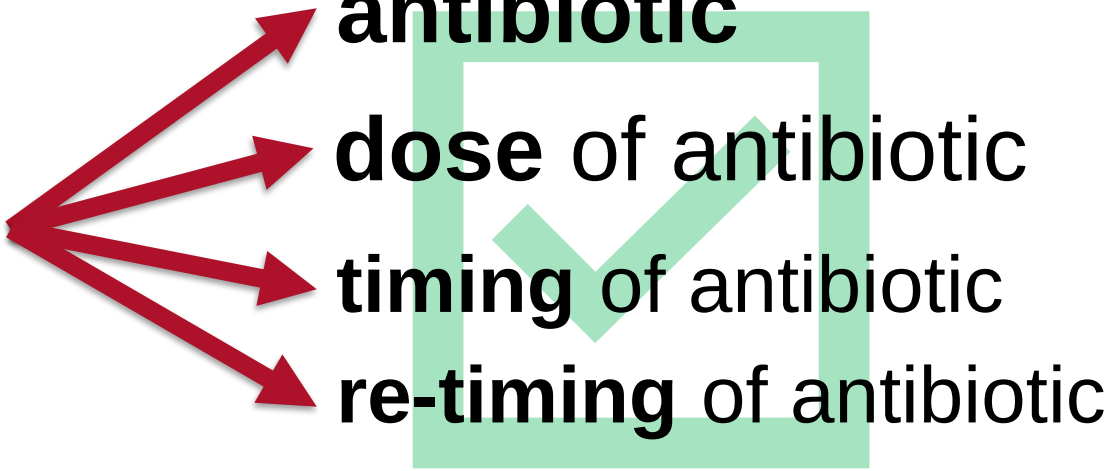


Glucose control (<150 mg/dL)

Hand Hygiene

Auditing – Antimicrobial Prophylaxis

Correct



antibiotic

dose of antibiotic

timing of antibiotic

re-timing of antibiotic

Discontinue antibiotic
after closure

Auditing

- Provide SSI audit and feedback to key stakeholders
  - Surgical and perioperative personnel
  - Hospital leadership
- Perform continual SSI surveillance
  - Target high-risk and high-volume operative procedures
- Track trends in audits

Review

- Variety of patient, surgical, and environmental risk factors for development of SSI
- Antimicrobial prophylaxis should be given 1 hour prior to incision (2 hours if vancomycin or fluoroquinolone)
  - Re-dose after 2 half lives of antibiotic timed from first dose (not procedure start time)
  - Use vancomycin for MRSA colonized patients if prosthetic material being placed
- Auditing for SSI should include pre-operative, operative, and post-operative phases of care

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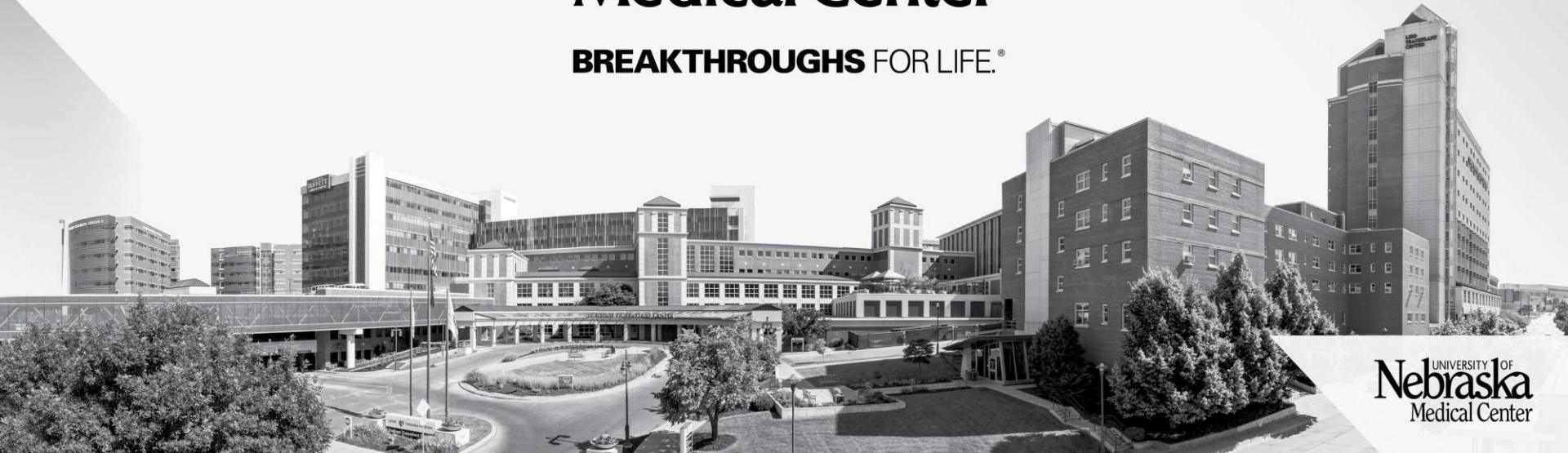

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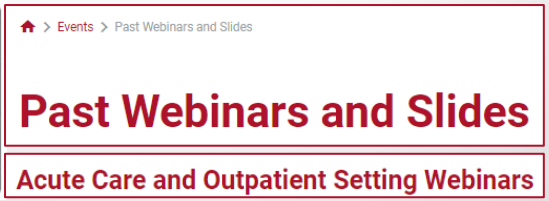
Questions & Answer Session

- Please use the Q&A box in the webinar platform to type a question to be read aloud.
  - If your question is not answered during the webinar, please call (402) 552-2881 Monday – Friday 8:00 am – 4:00 pm CST to speak with one of our Infection Preventionists or e-mail your question to nebraskaicap@nebraskamed.com

Slides & Webinar Recordings Available

- During this webinar, slides are available on the NE ICAP Acute Care webpage
- Visit the NE ICAP Past Webinars and Slides webpage
  - The slides and a recording of this webinar will be posted soon after the webinar
  - Also, various recent NE ICAP webinar slides and recordings are available



Misc. Updates & Upcoming Educational Opportunities

Kate Tyner, BSN, RN, CIC
Team Supervisor
Infection Preventionist, NE ICAP

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NE ICAP

2025 Nebraska ASAP Antimicrobial Stewardship Summit

This year's general session topics include:

- 2025 Nebraska Antimicrobial Stewardship Update
- DHHS Healthcare Associated Infections Update
- Keynote Address: Diagnostic Stewardship
- Hot Topics in Antimicrobial Stewardship
- Implementation Science in Antimicrobial Stewardship
- Communicating with Patients about Antibiotic Use
- Whole Genome Sequencing
- Approach to Immunocompromised Patients with Infectious Diseases
- Newly Approved Antibiotic Therapies

Click Here to Register! 2025 Nebraska Antimicrobial Stewardship Summit

NE ICAP

Register Now: Workshop for Healthcare Facility Water System Safety

Friday June 6
Lincoln

8 am	Welcome by Nebraska DHHS
8:15	From Plumbing to Patients: Christine Yount
8:45	Pathophysiology of Waterborne Pathogens: Richard Hankins
10:20	Water Treatment Basics: Mike Ballmer
12:20	Plumbing Basics: Jeffrey Bergers
1:20	Ensuring Safe Water: Comprehensive Strategies for Legionella Prevention in Healthcare Facilities: Jen Vogelsberg
3 pm	Uh-oh, Mitigation Approaches and Technology to Remediate When Your Water System is Implicated: Dr. Brooke Decker
4 pm	Closing: Lacey Pavlovsky

Registration Link

To register, click on or scan the QR code!

NICN: Primary Infection Prevention
April 3 and 4, Omaha

Offered only once in 2025!

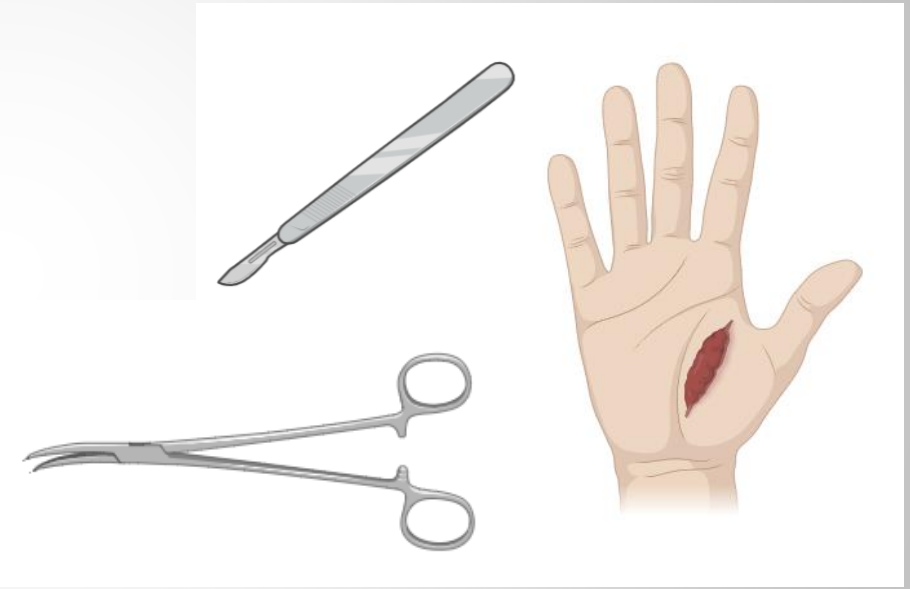
Track One: Acute Care, Ambulatory Care, and Surgical Centers
https://reg.learningstream.com/reg/event_page.aspx?ek=0009-0021-e9602b3592d14a05b2d74ca416d3a795

Track Two: Long-Term Care and Assisted Living Facilities
https://reg.learningstream.com/reg/event_page.aspx?ek=0009-0021-e9602b3592d14a05b2d74ca416d3a795

Join Us - Upcoming ICAP Webinars

- **April 9, 2025**
  - 12:00 – 1:00 PM (CST)
  - IPC Practices for SSI Prevention – Reducing Gaps & Validating Practices

- **May 14, 2025**
  - 12:00 – 1:00 PM (CST)
  - MDRO decolonization and role of CHG bathing
    - Dr. Richard Hankins



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You can request to be connected to an Infection Preventionist that specializes in your area, get added to our setting specific communication list for webinar and training invites, sign up for newsletters and reminders, or request an ICAR review for your facility.

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Webinar CE Process

1 Nursing Contact Hour is awarded by Nebraska ICAP

- Nebraska Infection Control Assessment and Promotion Program is approved as a provider of nursing continuing professional development by the Midwest Multistate Division, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

CNE Nursing Contact Hours:

✓Completion of survey is required.
- The survey must be specific to the individual obtaining credit (i.e.: 2 people cannot be listed on the same survey)
- Survey functionality is lost on mobile devices

✓One certificate is issued quarterly for all webinars attended
- Certificate comes directly from ICAP via email