Guidance and responses were provided based on information known on 08.14.25 and may become out of date. Guidance is being updated rapidly; users should look to CDC and NE DHHS guidance for updates.

# Long Term Care Webinar Series

## August 14, 2025

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

NE ICAP

NEBRASKA INFECTION CONTROL ASSESSMENT AND PROMOTION PROGRAM

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- Slides and a recording of this presentation will be available on the ICAP website: https://icap.nebraskamed.com/events/webinar-archive/
- Use the Q&A box in the webinar platform to type a question. Questions will be read aloud by the moderator. If your question is not answered during the webinar, please either e-mail NE ICAP or call during our office hours to speak with one of our IPs.

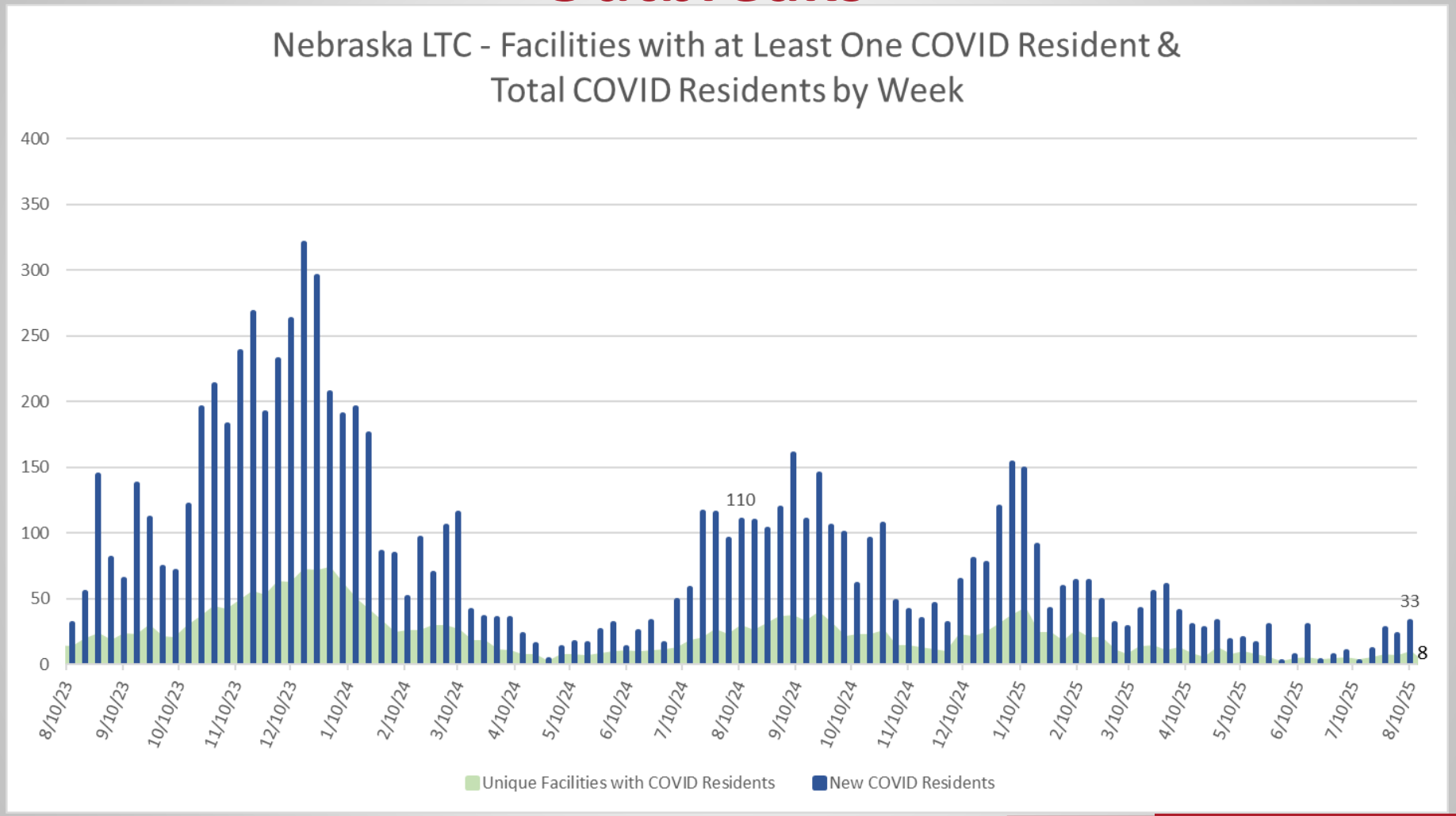
# Continuing Education Disclosures

- 1.0 Nursing Contact Hour is awarded for the LIVE viewing of this webinar
- In order to obtain the nursing contact hour, you must attend the entire live activity and complete the post webinar survey
- No relevant financial relationships were identified for any member of the planning committee or any presenter/author of the program content
- This CE is hosted Nebraska ICAP along with Nebraska DHHS
- 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

# Communicable Illnesses Update

NE ICAP

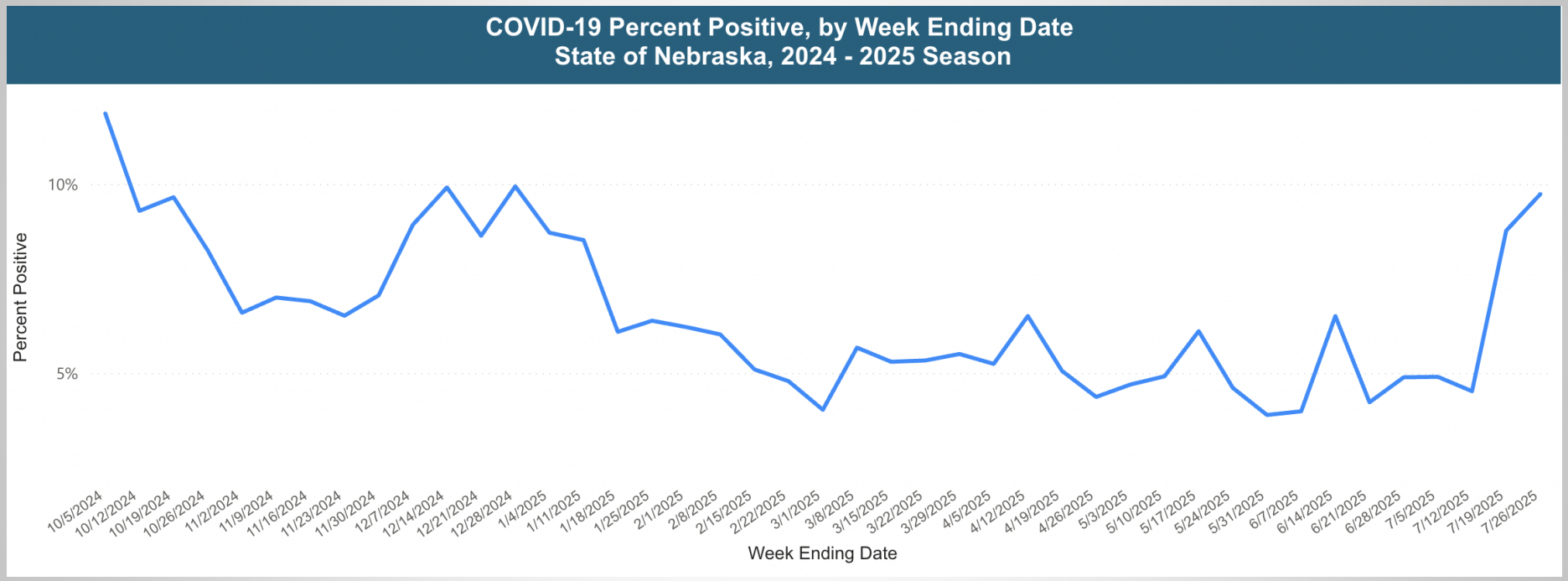
# Nebraska LTC Facility COVID-19 Outbreaks




**Updated: 8/11/2025
Source: Unofficial Counts Compiled by Nebraska ICAP based on data reported by facilities and DHHS; Actual numbers may vary.

NE ICAP

# Covid-19 NE DHHS Report

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# COVID Wastewater Surveillance

July 27, 2025 - August 02, 2025

Data from the most recent two weeks may be incomplete due to delays in data reporting. These data sets are subject to change and are indicated by the gray shading.

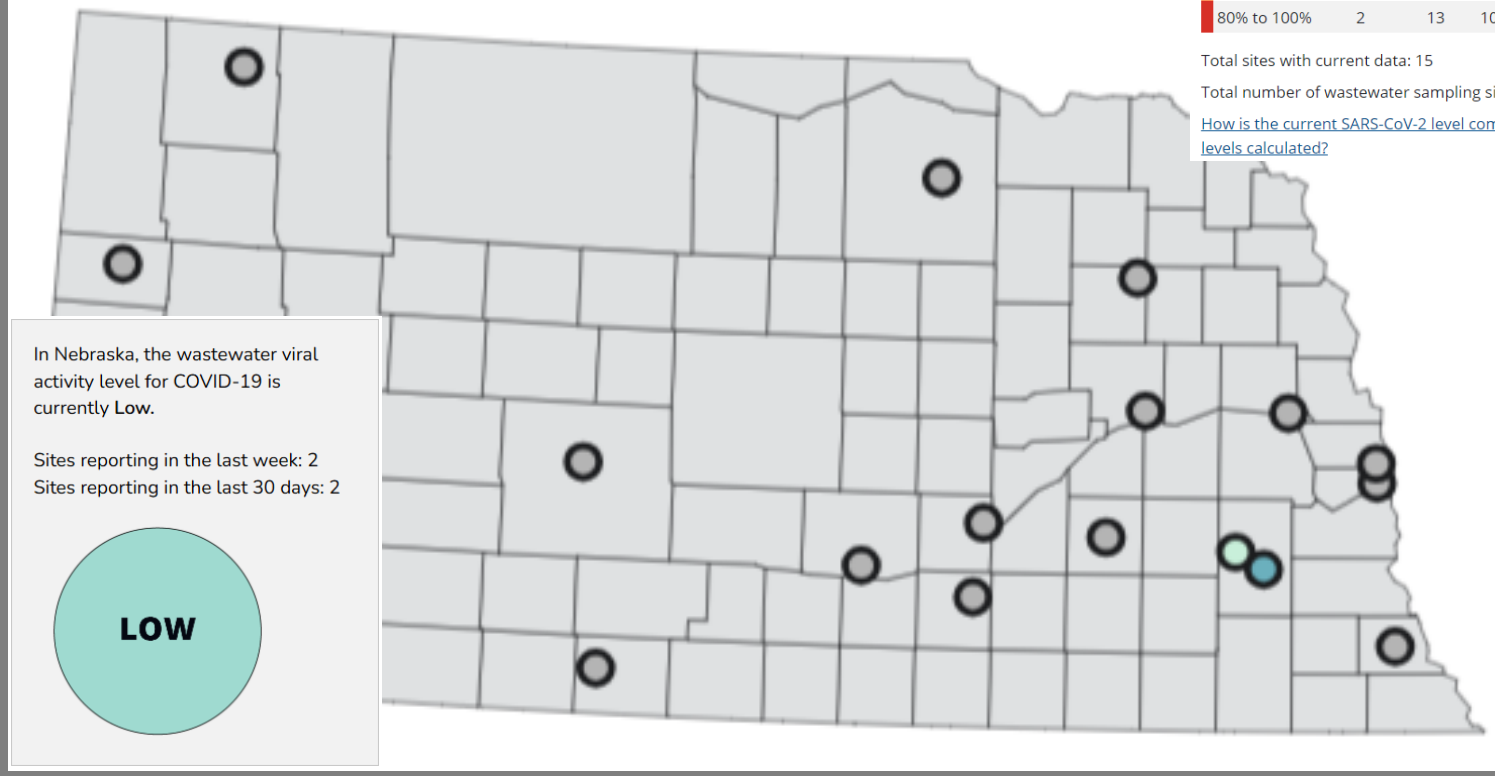
Current SARS-CoV-2 virus levels by site, Nebraska

| Current virus levels category | Num. sites | % sites | Category change in last 7 days |
|---|---|---|---|
| New Site | 1 | 7 | 0% |
| 0% to 19% | 0 | 0 | N/A** |
| 20% to 39% | 1 | 7 | 0% |
| 40% to 59% | 5 | 33 | 0% |
| 60% to 79% | 6 | 40 | – 14% |
| 80% to 100% | 2 | 13 | 100% |

Total sites with current data: 15

Total number of wastewater sampling sites: 18

How is the current SARS-CoV-2 level compared to past levels calculated?



In Nebraska, the wastewater viral activity level for COVID-19 is currently **Low**.

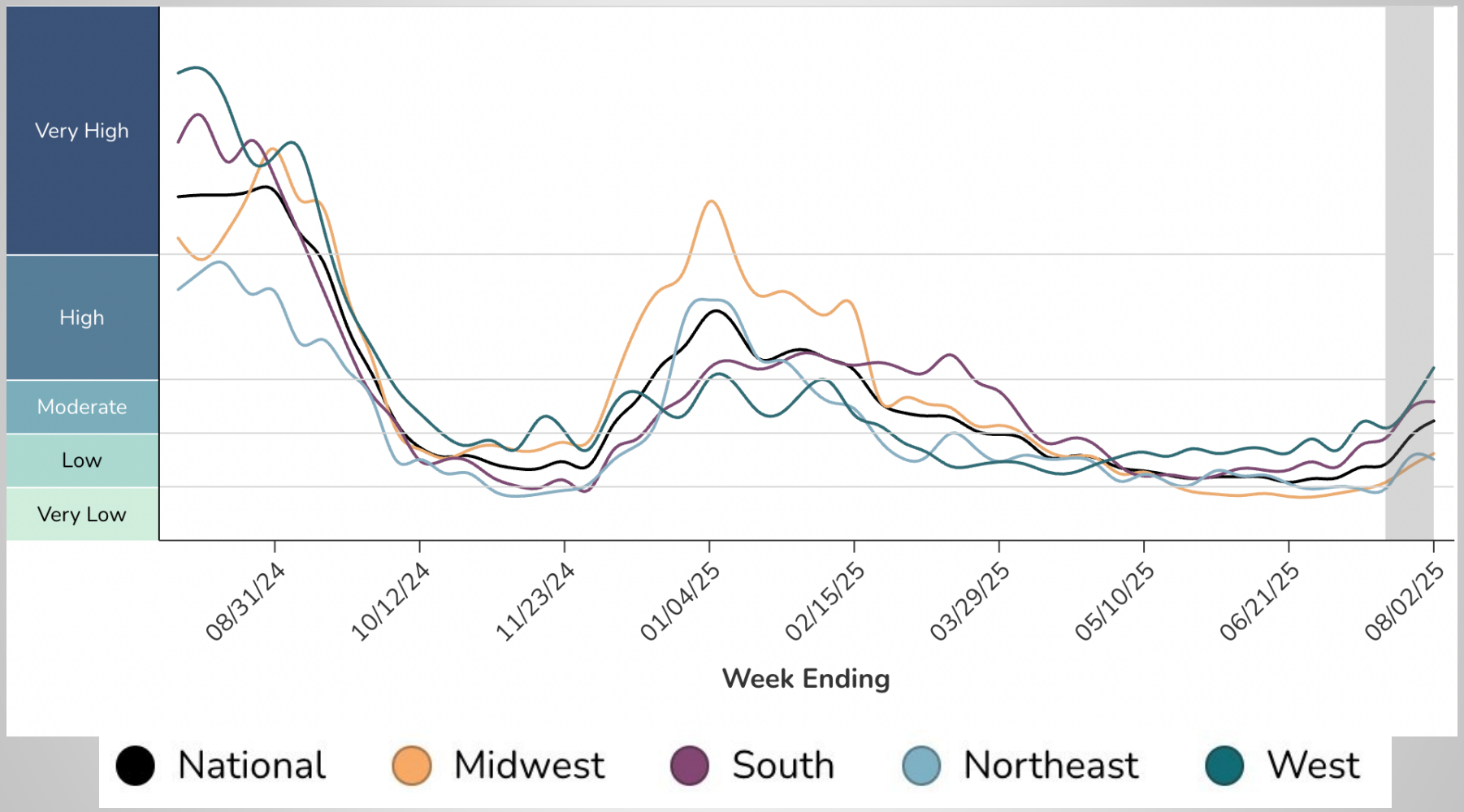
Sites reporting in the last week: 2
Sites reporting in the last 30 days: 2




CDC COVID Data Tracker: Wastewater Surveillance

NE ICAP

# COVID Wastewater Surveillance




CDC COVID Data Tracker: Wastewater Surveillance

COVID Data Tracker CDC

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# Measles Cases in US: Update as of 8/6/25

As of August 6, 2025, a total of **1,356** confirmed* measles cases were reported by 41 jurisdictions+

There have been 32 outbreaks (defined as 3 or more related cases) reported in 2025, and 87% of confirmed cases (1,177 of 1,356) are outbreak-associated.

- *For comparison, 16 outbreaks were reported during 2024 and 69% of cases (198 of 285) were outbreak-associated.*

*+ Alaska, Arkansas, Arizona, California, Colorado, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, New Jersey, New Mexico, New York City, New York State, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and Wyoming*

# Measles Cases in US: Update as of 8/6/25

## U.S. Cases in 2025

Total cases

**1356**

**Age**
Under 5 years: **386 (28%)**
5-19 years: **501 (37%)**
20+ years: **462 (34%)**
Age unknown: **7 (1%)**

**Vaccination Status**
Unvaccinated or Unknown: **92%**
One MMR dose: **4%**
Two MMR doses: **4%**

## U.S. Hospitalizations in 2025

**13%**

13% of cases hospitalized (171 of 1356).

**Percent of Age Group Hospitalized**
Under 5 years: **21% (82 of 386)**
5-19 years: **8% (40 of 501)**
20+ years: **11% (49 of 462)**
Age unknown: **0% (0 of 7)**

## U.S. Deaths in 2025

**3**

There have been 3 confirmed deaths from measles.

https://www.cdc.gov/measles/data-research/index.html

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# Measles – Preparation in Long Term Care

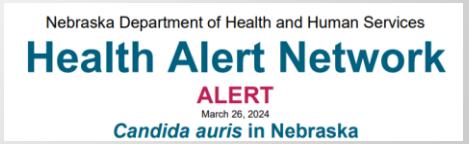
- Verify immunity of staff
- Review screening and isolation/work exclusion protocols
- Maintain PPE supplies
- Educate staff about signs and symptoms of measles
  - Early signs and symptoms of measles including fever, cough, coryza and red, watery eyes (conjunctivitis)
  - Measles rash appears 3 to 5 days after the first symptoms. It usually begins on the face and then spreads downward to the neck, trunk, arms, legs and feet.
- Discuss measles containment response plans with leadership/staff

PALTmed Measles Statement | PALTmed

# *Candida auris* – Nebraska Update

- Nebraska DHHS HAI team is investigating multiple clusters of *C. auris* identified in Nebraska in 2025.
- At this time, there have been 16 identified cases.
- The team is contact tracing and contacting facilities if any exposed persons have been admitted to a LTC facility.

- **Please ensure that your facility contact information is up-to-date for timely communication.**
  - Nebraska DHHS Facility Contact Inventory
- **Subscribe to Nebraska DHHS Health Alert Network updates**
  - Link to subscribe to HANs: https://dhhs.ne.gov/Pages/Health-Alert-Network.aspx
  - Link to prior *C. auris* HAN: https://dhhs.ne.gov/han%20Documents/ALERT03262024.pdf

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# *Candida auris* – Colonization Screening

Screening patients for *C. auris* colonization is critical for preventing the spread of *C. auris*. Noninvasive skin swab collection and testing can identify patients who are colonized with *C. auris.*

Image Courtesy of CDC

Screening Recommendations for Healthcare Facilities | Candida auris (C. auris) | CDC
C. auris Screening: Patient Swab Collection | Candida auris (C. auris) | CDC

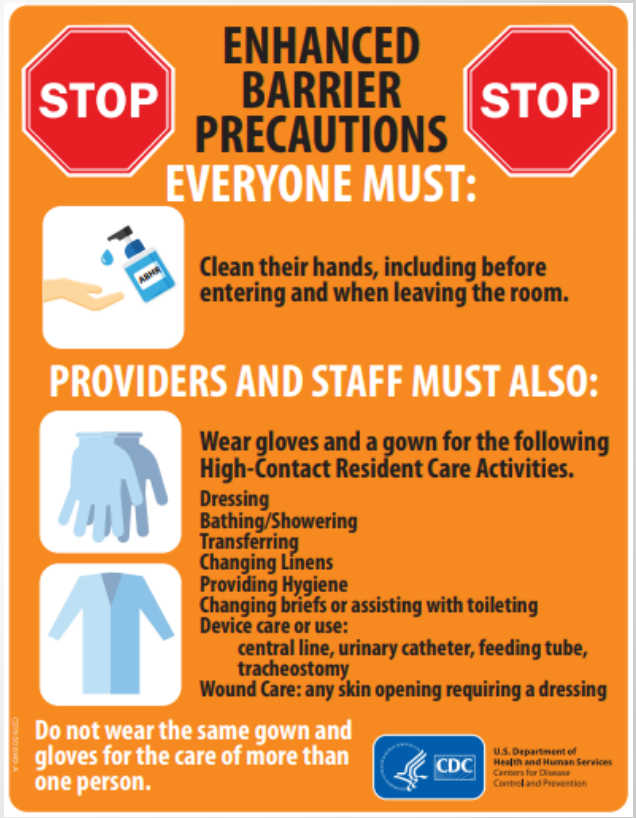
NE ICAP

# *Candida auris - EBP*

**Screening should be used to inform infection control measures to prevent transmission and not be used to deny or delay transfers. Long term care facilities are equipped to care for residents colonized with Candida auris with use of enhanced barrier precautions (EBP).**

Examples of MDROs currently targeted by CDC include:

- Pan-resistant organisms,
- Carbapenemase-producing carbapenem-resistant Enterobacterales,
- Carbapenemase-producing carbapenem-resistant *Pseudomonas*,
- Carbapenemase-producing carbapenem-resistant *Acinetobacter baumannii*, and
- *Candida auris*

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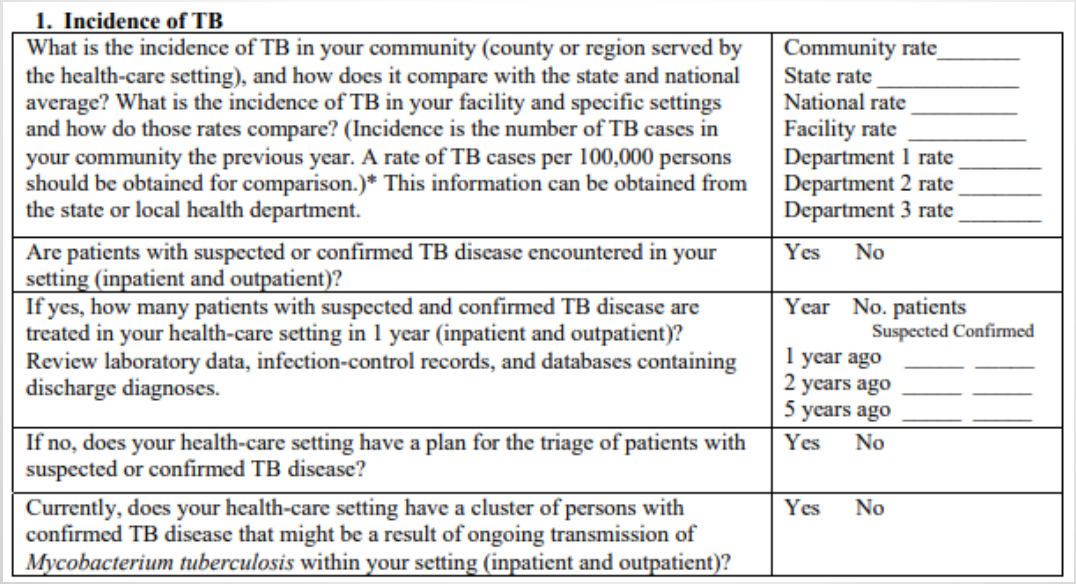
# Tuberculosis – Nebraska Update

The **Tuberculosis Annual Report - 2024** is now available.

- https://dhhs.ne.gov/Pages/Tuberculosis.aspx

CDC Tuberculosis Risk Assessment for Health Care Facilities

- https://www.cdc.gov/tb-healthcare-settings/hcp/facility-risk-assessment/index.html



**1. Incidence of TB**

| | |
|---|---|
| What is the incidence of TB in your community (county or region served by the health-care setting), and how does it compare with the state and national average? What is the incidence of TB in your facility and specific settings and how do those rates compare? (Incidence is the number of TB cases in your community the previous year. A rate of TB cases per 100,000 persons should be obtained for comparison.)* This information can be obtained from the state or local health department. | Community rate_____<br>State rate _____<br>National rate _____<br>Facility rate _____<br>Department 1 rate _____<br>Department 2 rate _____<br>Department 3 rate _____ |
| Are patients with suspected or confirmed TB disease encountered in your setting (inpatient and outpatient)? | Yes No |
| If yes, how many patients with suspected and confirmed TB disease are treated in your health-care setting in 1 year (inpatient and outpatient)? Review laboratory data, infection-control records, and databases containing discharge diagnoses. | Year No. patients<br>Suspected Confirmed<br>1 year ago _____ _____<br>2 years ago _____ _____<br>5 years ago _____ _____ |
| If no, does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease? | Yes No |
| Currently, does your health-care setting have a cluster of persons with confirmed TB disease that might be a result of ongoing transmission of *Mycobacterium tuberculosis* within your setting (inpatient and outpatient)? | Yes No |

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# Tuberculosis – HCP Screening

All health care personnel should be screened for TB upon hire (i.e., preplacement) and new residents screened upon admission. TB screening is a process that includes:

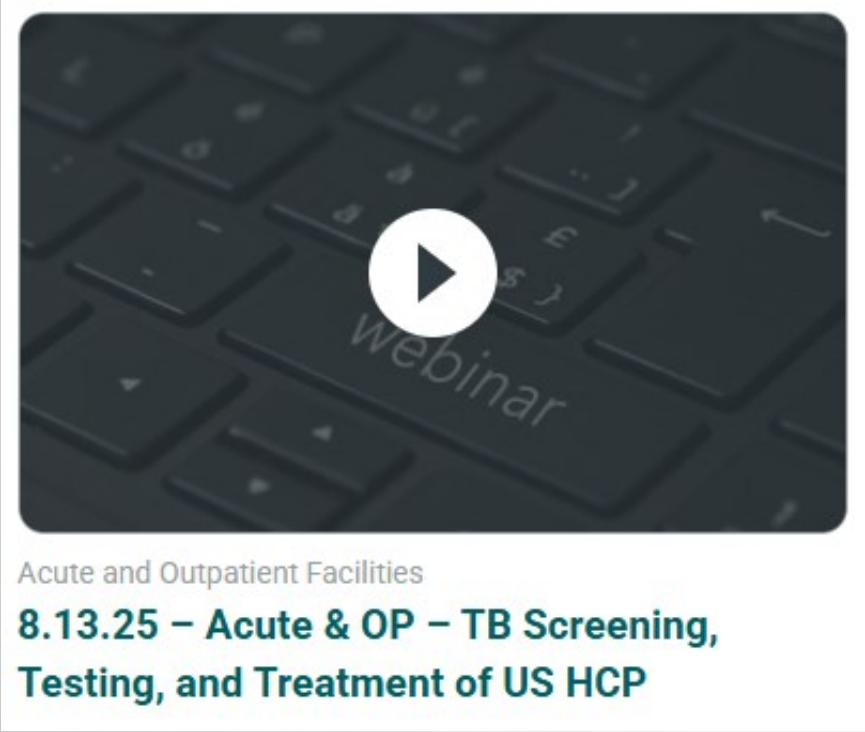
- A baseline individual TB risk assessment,
- TB symptom evaluation,
- A TB test (e.g., TB blood test or a TB skin test), and
- Additional evaluation for TB disease as needed

Routine serial TB screening or testing at any interval after baseline (e.g., annually) is **not** recommended unless there is a known exposure or ongoing transmission at a healthcare facility.

Baseline Tuberculosis Screening and Testing for Health Care Personnel | TB Prevention in Health Care Settings | CDC

Frequency of Tuberculosis Screening and Testing for Health Care Personnel | TB Prevention in Health Care Settings | CDC

# Tuberculosis – ICAP Webinar 8/13/25




Video Link:
https://echo360.org/media/1f1db7af-d28d-4aaa-ad08-e7d1fc3bd972/public

Slide Deck:
https://icap.nebraskamed.com/wp-content/uploads/sites/2/2025/08/2025.08.13-Acute-and-OP-Webinar.pdf

NE ICAP

APIC NEBRASKA

Nebraska Infection Control Network

NEBRASKA METHODIST COLLEGE
THE JOSIE HARPER CAMPUS
PROFESSIONAL DEVELOPMENT

# The NICN and APIC NE Symposium: 45 Years of Progress: Advancing Infection Prevention and Control Together

| Time CST | Topic/Title/Speaker/Contact hours Awarded |
|---|---|
| 7:00am-8:15am | Registration/Breakfast |
| 8:15am-8:30am | Welcome: Dr. Richard Starlin (0.25 CH) |
| 8:30am-9:15am | Future of Infection Prevention: Dr. Gonzalo Bearman (0.75 CH) |
| 9:15am-10:00am | Leadership Development & Influencing Change: Dr. Hilary Babcock (0.75 CH) |
| 10:00am-10:30am | Break/Vendors |
| 10:30am-11:30am | Vaccination Promotion: Dr. Peter Hotez (presenting remotely. 0.0 CH) |
| 11:30am-12:30pm | Lunch (Provided) and Vendors |
| 12:30pm-1:30pm | Track 1: Infection Prevention and Control Updates for the Post-Acute and Long-Term Care Settings: Dr. Muhammad Ashraf (1.0 CH) |
| 12:30pm-1:30pm | Track 2: Vascular Access Related Infection: Prevention, Device Management, Preventative Technologies: Barb Nickel (1.0 CH) |
| 1:30pm-2:00pm | Break/Vendors |
| 2:00pm-2:45pm | MDRO in Animals: Stephen Cole (0.75 CH) |
| 2:45pm-3:30pm | How to Interact with the Media and Art of Communication: Cathy Wyatt (0.75 CH) |
| 3:30pm-3:45pm | Closing (0.25 CH) |

Join NICN and APIC NE for their 45th anniversary symposium. Join us for an engaging and informative workshop dedicated to infection prevention and control in all healthcare settings

- Friday, August 29, 2025
- 8:00 AM to 3:15 PM
- The Holland Center, Omaha, NE 68102

NICN APIC Nebraska Symposium Registration

NICN Scholarship Form

NE ICAP

# Managing a COVID Outbreak

NE ICAP

# COVID-19 Vaccination

Staying up-to-date with COVID-19 vaccine gives the best protection from the currently circulating strains. Vaccination is especially important for persons over 65 years old and those that live in a long-term care facility.

**Age 65 years and older**

- **Unvaccinated:** follow recommendations above for unvaccinated persons ages 19–64 years **and** administer dose 2 of 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months).
- **Previously vaccinated before 2024–25 vaccine:** follow recommendations above for previously vaccinated persons ages 19–64 years **and** administer dose 2 of 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months).

Adult Immunization Schedule Notes | Vaccines & Immunizations | CDC

# Stay Prepared to Prevent a Respiratory Illness Outbreak

**Ensure everyone is aware of recommended IPC practices in the facility.**

- Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias).
- Include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene).
- Dating these alerts can help ensure people know that they reflect current recommendations.

**Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have a diagnosis or symptoms of communicable illness.**

- Visitors with COVID-19 should defer non-urgent in-person visitation until they have met the healthcare criteria to end isolation (10 days).
- Visitors who have had close contact with someone with COVID-19, it is safest to defer non-urgent in-person visitation until 10 days after their close contact.

Infection Control Guidance: SARS-CoV-2 | COVID-19 | CDC

# Managing a COVID-19 Outbreak

**CDC Recommendations:**

- Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic
  - Infection Control Guidance: SARS-CoV-2 | COVID-19 | CDC
- Interim Guidance for Managing Healthcare Personnel With SARS-CoV-2 Infection or Exposure
  - Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | COVID-19 | CDC

**ICAP Resources:**

- ICAP-Summary-of-Recommendations-for-COVID-19-in-a-Long-Term-Care-Facility-5.11.23.pdf
- Zones-and-PPE.pdf

| Zone | Resident Masking | Staff PPE | Testing | Notes |
|---|---|---|---|---|
| Red Zone Isolation (Residents with a positive COVID-19 Test) | Resident isolated to room. | COVID-19 full PPE: Respirator, eye protection, isolation gown, and gloves.<br>Respirator and eye protection may be used according to extended use guidance [if they are not touched] | Repeat testing is not needed to exit isolation unless test-based strategy being used to determine isolation duration for immunocompromised resident. | Room door closed; Communal activity and dining are restricted; and therapy or bathing are preferably performed in the resident room. Designated isolation zone in building with dedicated staff is ideal. Follow relevant regulations that apply to changing resident rooms. |
| Light Red Zone Isolation (Symptomatic resident with COVID-19 test pending) | Resident isolated to room. | COVID-19 full PPE: Respirator, eye protection, isolation gown, and gloves.<br>Respirator and eye protection may be used according to extended use guidance [if they are not touched] | If using an antigen test, a negative result should be confirmed by either a negative PCR or second negative antigen test taken 48 hours after the first negative test. | Room door closed; Communal activity and dining are restricted; and therapy or bathing are preferably performed in the resident room.<br><br>Resident should not be moved to a COVID unit until positive status confirmed. |
| Tan Zone (Facility in outbreak status) | Everyone should mask in communal areas of facility. | Everyone should mask in communal areas of facility.<br><br>Facility should consider universal use of N95 and protective eyewear for staff when facility is in outbreak, especially when residents unable to use source control or area is poorly ventilated. | Contact tracing approach can be used when facility able to clearly identify exposures (e.g., single resident exposure to a visitor).<br><br>Broad-based (unit wide) approach is preferred when contacts cannot be identified, or additional cases are identified after contact tracing approach.<br><br>*Outbreak testing is not recommended for asymptomatic persons with SARS-CoV-2 infection in the prior 30 days. | **Initial Testing:** Perform a series of three tests, 48 hours apart. This will typically be at day 1 (exposure day 0), day 3, day 5.<br><br>**Follow-up testing if additional cases identified:** Test every 3 days (twice weekly) until 14 days have passed since last known positive test.<br><br>If concerns exist for outbreak containment (e.g., large number of resident cases, ongoing transmission etc.) facilities should consider using yellow zone instead of Tan Zone |
| Green Zone (No current outbreak) | Broader use of source control per facility policy, based on risk assessment.<br>Perform risk assessment to identify higher levels of community COVID-19 or other respiratory illness transmission. | Broader use of source control per facility policy, based on risk assessment.<br><br>Facility should consider universal use of N95 and protective eyewear when there are higher levels of COVID-19 transmission in the community. | No routine testing.<br><br>Perform test on anyone with even mild symptoms of COVID-19. | Promote core principles of COVID-19 infection prevention:<br>• Hand hygiene<br>• Use of PPE per standard precautions<br>• Respiratory hygiene/cough etiquette<br>• Cleaning and disinfection of environmental surfaces<br>• Instructional signage throughout facility |
| Gray Zone (New admission or readmission to facility) | Masking is at facility discretion, unless resident reports exposure or symptoms. | Healthcare personnel wear well-fitting source control based on facility policy and outbreak status. | Testing is at facility discretion, unless resident reports exposure or symptoms. | Quarantine not required for gray zone. However, if resident reports symptoms, follow light red zone recommendations |

# Source Control During Outbreak

**Source control** should be recommended for all staff, visitors, and residents until the outbreak is over (e.g., no new cases have been identified for 14 days).

Consider facility policy requiring universal use of N95 respirators and protective eyewear for all staff in affected areas of the facility.

# Outbreak Testing

**Contact Tracing** (use for limited exposure, such as resident exposure to family member)

**Broad-based testing** (i.e., unit, floor, or entire building) is preferred if all potential contacts cannot be identified or managed with contact tracing. Also use broad-based testing when multiple positive cases have been identified in building.

**Initial Testing**

- Perform a series of three tests, 48 hours apart. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5
- If no additional cases are identified, outbreak testing ends. If additional cases are identified, initiate broad-based testing.

**Follow-up Testing** (when outbreak testing has identified additional infections

- Testing is recommended every 3 days (twice weekly) until 14 days have passed since last known positive test.

*Note: Testing is generally not recommended for asymptomatic individuals who have recovered in the **prior 30 days**.*

# Isolation Duration – Resident(s)

- At least **10 days** have passed *since symptoms first appeared,* **and** at least 24 hours have passed *since last fever* without the use of fever-reducing medications, **and** symptoms (e.g., cough, shortness of breath) have improved.

- Residents that are moderately to severely immunocompromised or who are identified to have a severe or critical infection, may require up to 20 days of isolation. Consider use of a test-based strategy to discontinue isolation.

Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC

# Infected Staff – Return to Work

Staff diagnosed with COVID-19 need to be restricted from work until at least 7 days have passed since symptoms first appeared (or from the date of positive test if asymptomatic), AND they have resolution of fever and an improvement of symptoms, AND negative viral testing.

- If using an antigen test, staff member should have a negative test obtained on day 5 and again 48 hours later.
- If the staff member tests positive on day 5 - 7 or testing is not performed between day 5-7 then restriction will need to be extended for at least 10 days.

# Room Placement

Ideally, residents should be placed in a single-person room.

- If limited single rooms are available, or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should remain in their current location.

- Facilities will need to follow all relevant regulations that apply to changing resident rooms, including securing consent from resident/families.

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If unable to move roommates, consider other measures to prevent further exposure:

- Maintain physical distancing as much as possible.
- Separate residents with privacy curtain.
- Mask resident, as able, if crossing into separate areas of room (i.e., bathroom visit).
- Increase disinfection of surfaces in room and bathroom

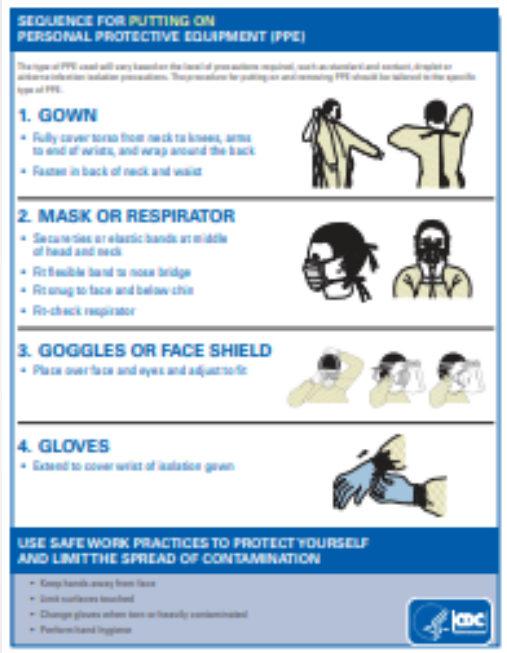
# Isolation – PPE Use

Staff entering the room of a resident with COVID-19 should adhere to standard precautions and COVID-19 isolation, with use of respirator (N95), gown, gloves, and eye protection.

- **Standardize isolation signs** to include required PPE. Recommend signage to indicate donning and doffing techniques.

- **Training** – When and how to don and doff PPE
  - Ensure gown and gloves are doffed inside of the resident room, prior to exiting into hallway.

- **Audits** – Provide real time feedback for improvement.




ppe-sequence-p.pdf (cdc.gov)

# Yellow Zone

Yellow Zone Transmission-Based Precaution measures should be implemented in the event of ongoing COVID-19 transmission within the facility that is not controlled with initial interventions.

Shift to Yellow Zone Phases instead of Tan Zones when there are concerns related to outbreak containment (e.g., large number of resident cases or ongoing transmission, such as new RESIDENT cases being identified COVID-19 positive in rounds of testing 7 days or more after the first residents(s) identified COVID-19 positive).

Yellow Zone does **not** need to be considered if facility has only staff positive cases identified during outbreak testing.

| Yellow Zone (Uncontrolled COVID-19 outbreak) | **Yellow Zone Phase** | **Staff PPE Use** | **Additional Transmission-Based Precautions Recommended** |
|---|---|---|---|
| | Phase 1 | Staff universal use of N95 and eye protection.<br><br>Respirator and eye protection may be used according to extended use guidance [if they are not touched] | Resident wear source control when outside of room.<br>Restrict communal dining.<br>Small group activities can continue with source control and physical distancing. |
| | Phase 2 | Staff universal use of N95 and eye protection.<br><br>Respirator and eye protection may be used according to extended use guidance [if they are not touched] | Resident wear source control when outside of room.<br>Restrict dining and group activities. |
| | Phase 3 | COVID-19 full PPE: Respirator, eye protection, isolation gown, and gloves.<br><br>Respirator and eye protection may be used according to extended use guidance [if they are not touched] | Residents mostly limited to their rooms.<br>Keep resident doors closed.<br>Restrict dining and group activities.<br>Facility can devise a plan for a small number of residents to be outside of their room at any given time with mask use. Facility should ensure physical distancing and could prioritize outdoor visits, dependent on weather. |

Note: Facility can choose to initiate yellow zone precautions with any of the three phases listed above depending on their assessment of outbreak (e.g., nature of exposure, ability of residents to follow instructions, ventilation in the building, number of staff and resident cases etc.). However, if facility continues to see resident cases 7 days after implementing a lower-level phase, then proceed to a higher-level phase. If already on phase 3 and still seeing new cases 7 days later, reassess infection control practices and consider reaching out to Nebraska ICAP to discuss additional infection control measures.

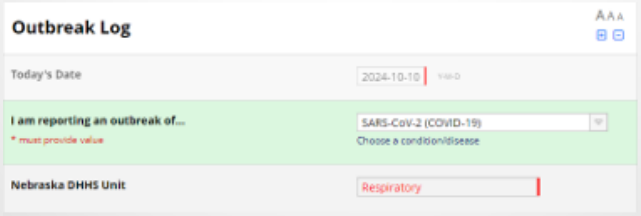
# Outbreak Reporting Requirements

**Long-term care facilities** that are CMS certified are required to report to NHSN. NHSN reporting satisfies the requirement to report the COVID, influenza and/or RSV outbreaks to the state (DHHS).

- CDC | NHSN Recent Trainings

**Assisted living facilities** can meet the requirement to report outbreak through completion of Redcap survey:

- https://epi-dhhs.ne.gov/redcap/surveys/?s=HFDCEHEYT844R8C8



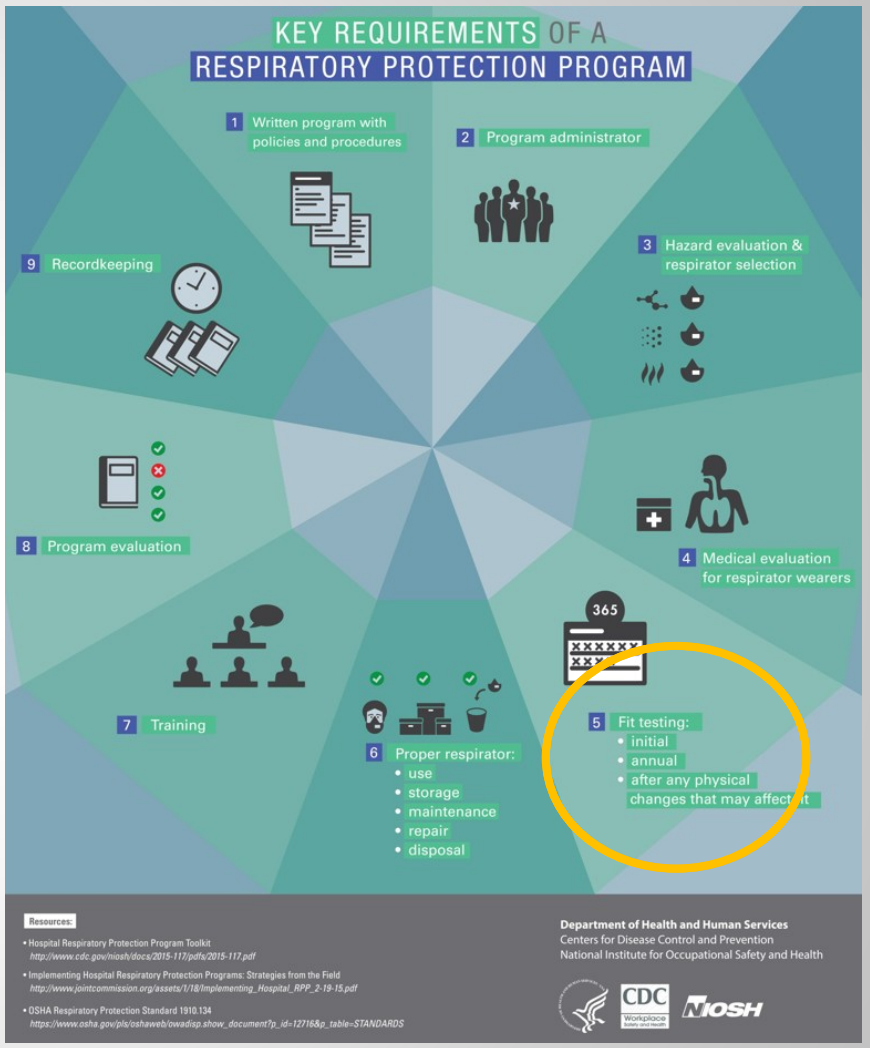

- Note: Also inform local health department of outbreak, depending on specific local health department expectation.

# Respiratory Protection Program - Reminders

Is your facility keeping up with annual N-95 respirator fit testing?

[Healthcare Respiratory Protection | Healthcare Workers | CDC]

[Hospital Respiratory Protection Program Toolkit | Healthcare Workers | CDC]

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# Engaging Staff in IPC Activities

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It's not possible to prevent infections. It's out of my control and there is only so much that I can do.

We are already following all the best practices.

I am too busy for this.

I am only one person. I can't make a difference.

Factors that prevent behavior change:

- Confusion
- Anxiety
- Frustration
- False Starts

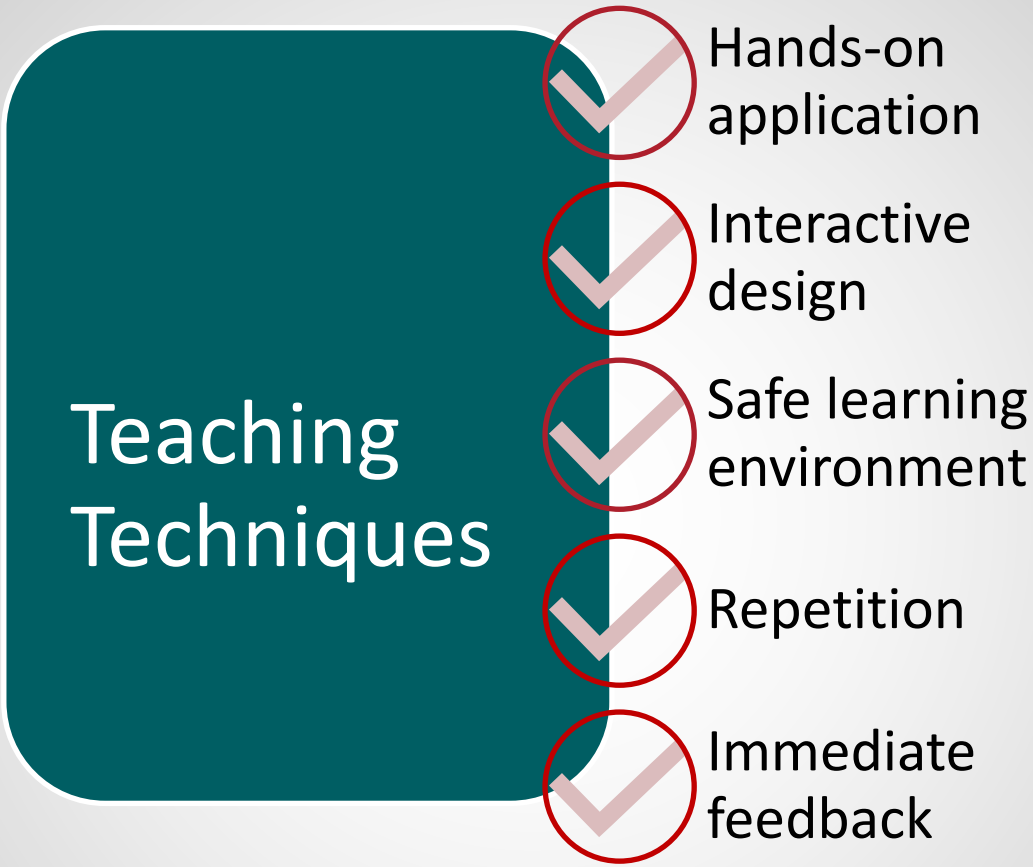
# Factors that lead to behavior change

- A clear why
- What's in it for me?
- Training
- Resources/tools
- Action plan

# Knowledge does not equal behavior change.

Key concepts in adult learning:

- Pull from experience
- Make it applicable
- Driven by internal motivation
- Need to know the reason for learning something


Teaching Techniques
Hands-on application
Interactive design
Safe learning environment
Repetition
Immediate feedback

PROJECT FIRSTLINE
CDC's National Training Collaborative for Healthcare Infection Prevention & Control

[Ventilation in Healthcare Settings Factsheet | Project Firstline | CDC]


[Image Courtesy of CDC]

# VENTILATION IN HEALTHCARE SETTINGS

In healthcare settings, ventilation is important because it helps remove things from the air that we don't want to breathe in – like small virus particles. Good ventilation improves air quality and reduces the risk of germs spreading.

## WHAT TO KNOW

**Understand what an air change is and why recommended air changes per hour are important in healthcare.**

- An air change means the air in a room is replaced with new air.
- Air changes are usually measured by the hour – air changes per hour (ACH).
- In healthcare facilities, nearly every type of room has a recommended number of ACHs to help reduce the risk of germs spreading among patients and staff.

**Respect wait times to allow the air in rooms to clear.**

- The infection prevention or clinical leaders in your area, like your nurse manager, will use the ACH to figure out how long a room should sit empty after a patient with a possible or confirmed respiratory infection has left.
- It is okay to enter a room before the air is completely cleared, including while the patient is still there, if you use the recommended personal protective equipment (PPE).

**Ask before making changes to the ventilation in a room.**

- Rooms are often connected in healthcare facilities.
- Making a change to the ventilation in one room – like opening a window or closing vents to adjust temperature – can change the ventilation in other places, too.
- **That's why it's important to talk to the person or team at your facility that is responsible for maintaining air filtration and ventilation if you have concerns about the ventilation in a room.**

**Make sure vents are not blocked.**

- A blocked vent could prevent the ventilation system from functioning like it is supposed to.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

PROJECT FIRSTLINE
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cdc.gov/ProjectFirstline

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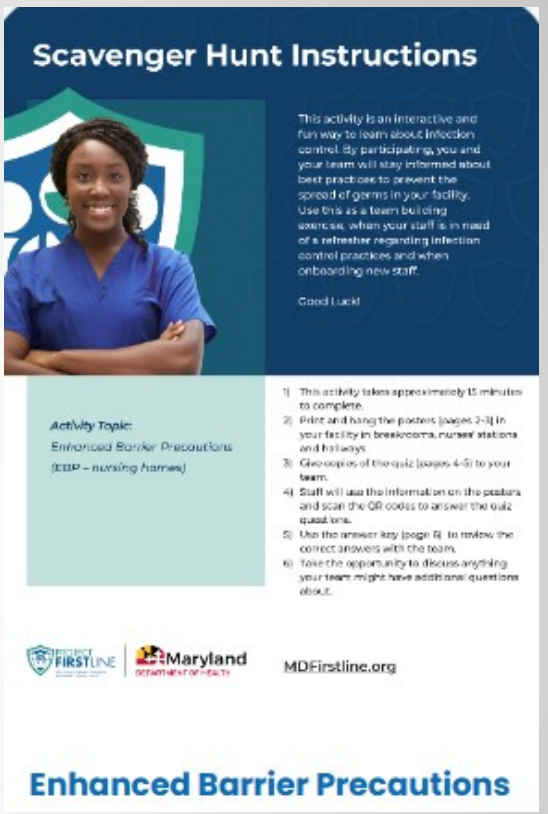
# Interactive Training Tools


https://www.naccho.org/uploads/card-images/naccho-general/The-Project-Firstline-Escape-Room-and-Other-IPC-Education-and-Communication-Tools.pdf




https://mdfirstline.org/training/

# In Closing

NE ICAP

# Join Us - Upcoming NE ICAP Webinars

- September 11, 2025
  - 12:00 – 1:00 PM (CST)
    - Dietary Services & Food Safety: Key Points for Infection Preventionists in Healthcare Settings


- October 9, 2025
  - 12:00 – 1:00 PM (CST)
    - Antibiotic Awareness

BE ANTIBIOTICS AWARE
SMART USE, BEST CARE

APIC NEBRASKA

Nebraska Infection Control Network

NEBRASKA METHODIST COLLEGE
THE JOSIE HARPER CAMPUS
PROFESSIONAL DEVELOPMENT

# The NICN and APIC NE Symposium: 45 Years of Progress: Advancing Infection Prevention and Control Together

| Time CST | Topic/Title/Speaker/Contact hours Awarded |
|---|---|
| 7:00am-8:15am | Registration/Breakfast |
| 8:15am-8:30am | Welcome: Dr. Richard Starlin (0.25 CH) |
| 8:30am-9:15am | Future of Infection Prevention: Dr. Gonzalo Bearman (0.75 CH) |
| 9:15am-10:00am | Leadership Development & Influencing Change: Dr. Hilary Babcock (0.75 CH) |
| 10:00am-10:30am | Break/Vendors |
| 10:30am-11:30am | Vaccination Promotion: Dr. Peter Hotez (presenting remotely. 0.0 CH) |
| 11:30am-12:30pm | Lunch (Provided) and Vendors |
| 12:30pm-1:30pm | Track 1: Infection Prevention and Control Updates for the Post-Acute and Long-Term Care Settings: Dr. Muhammad Ashraf (1.0 CH) |
| 12:30pm-1:30pm | Track 2: Vascular Access Related Infection: Prevention, Device Management, Preventative Technologies: Barb Nickel (1.0 CH) |
| 1:30pm-2:00pm | Break/Vendors |
| 2:00pm-2:45pm | MDRO in Animals: Stephen Cole (0.75 CH) |
| 2:45pm-3:30pm | How to Interact with the Media and Art of Communication: Cathy Wyatt (0.75 CH) |
| 3:30pm-3:45pm | Closing (0.25 CH) |

Join NICN and APIC NE for their 45th anniversary symposium. Join us for an engaging and informative workshop dedicated to infection prevention and control in all healthcare settings

- Friday, August 29, 2025
- 8:00 AM to 3:15 PM
- The Holland Center, Omaha, NE 68102

NICN APIC Nebraska Symposium Registration

NE ICAP

# 2 Newer Items Added to the

NE ICAP ASAP Learning Center
ICAP/ ASAP Education on Your Own Time

## Courses

Thank you for exploring the courses Nebraska ICAP/ ASAP have to offer. All users must be registered to take a course with Nebraska ICAP/ ASAP.

**New users**: Please click on the "Registration" tab at the top of the page to create an account.

**Registered users**: Login below or you will be asked to login when you select a course.

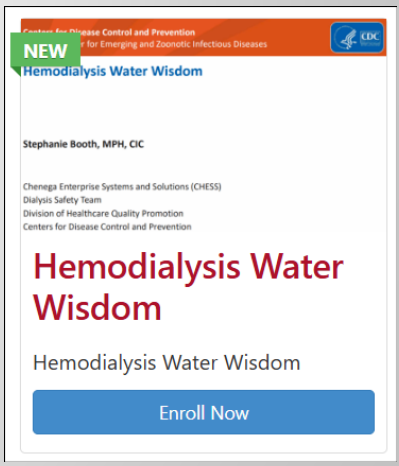
Login

Designed for front-line HCP, quiz & certificate.


Safe Injection Practices and Drug Diversion Awareness

Safe Injection Practices and Drug Diversion Awareness. This course is worth 1.0 CE Credits.

Enroll Now




Hemodialysis Water Wisdom

Hemodialysis Water Wisdom

Enroll Now

https://icapasaplearning.nebraskamed.com/

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# Infection Control Assessment & Response (ICAR) Visits

- On-site infection control assessment and response visits are available. Can be general or focused including the following:
  - Transmission-based precautions and EBP
  - Device Reprocessing
  - Water Management Program
  - Among other domains, to be tailored to your facility

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# Infection Prevention and Control Hotline Number:

## Call 402-552-2881

**Office Hours** are Monday – Friday
8:00 AM - 4:00 PM Central Time

*Messages left outside of office hours will be answered the next business day.
**Please call the main hotline number to ensure the quickest response.

# Webinar CE Process

**1 Nursing Contact Hour is offered for attending this LIVE webinar.**

**Individual surveys must be completed for each attendee.**

Questions? Contact us at:

nebraskaicap@nebraskamed.com 402-552-2881

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