Guidance and responses were provided based on information known on 11.13.25 and may become out of date. Guidance is being updated rapidly; users should look to CDC and NE DHHS guidance for updates.

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Long Term Care Webinar Series

November 13, 2025

NE ICAP

NEBRASKA INFECTION CONTROL ASSESSMENT AND PROMOTION PROGRAM

Presentation Information

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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.

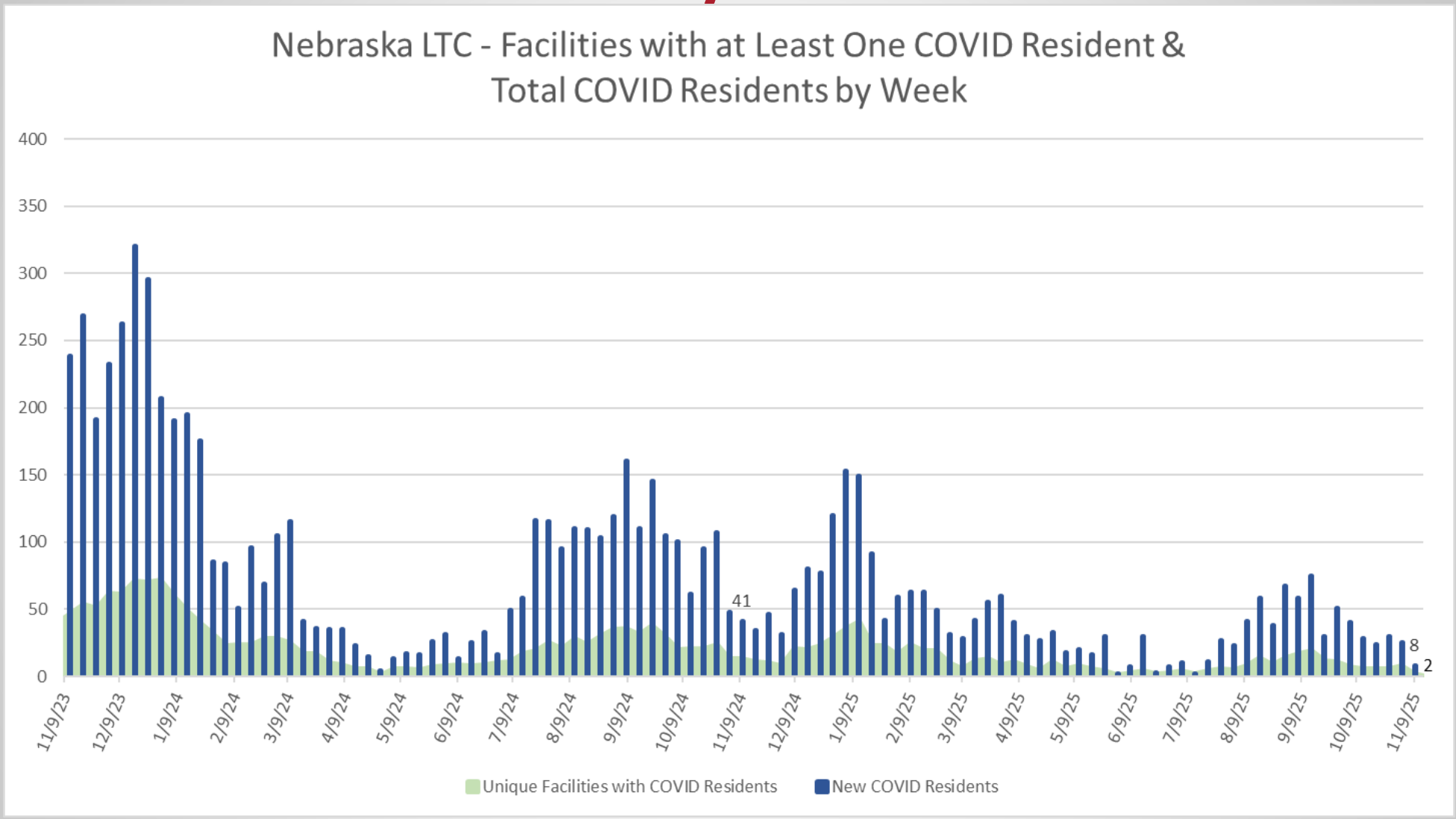
Continuing Education Disclosures

- 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 VTL Center for Professional Development, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation

Communicable Illness Update

NE ICAP

Nebraska LTC Facility COVID-19 Outbreaks



**Updated: 11/10/2025
Source: Unofficial Counts Compiled by Nebraska ICAP based on data reported by facilities and DHHS; Actual numbers may vary.

Influenza Surveillance Data, MMWR Week 44

All data are preliminary and may change as more reports are received. Data through week ending 11/1/2025

INFLUENZA LABORATORY SURVEILLANCE

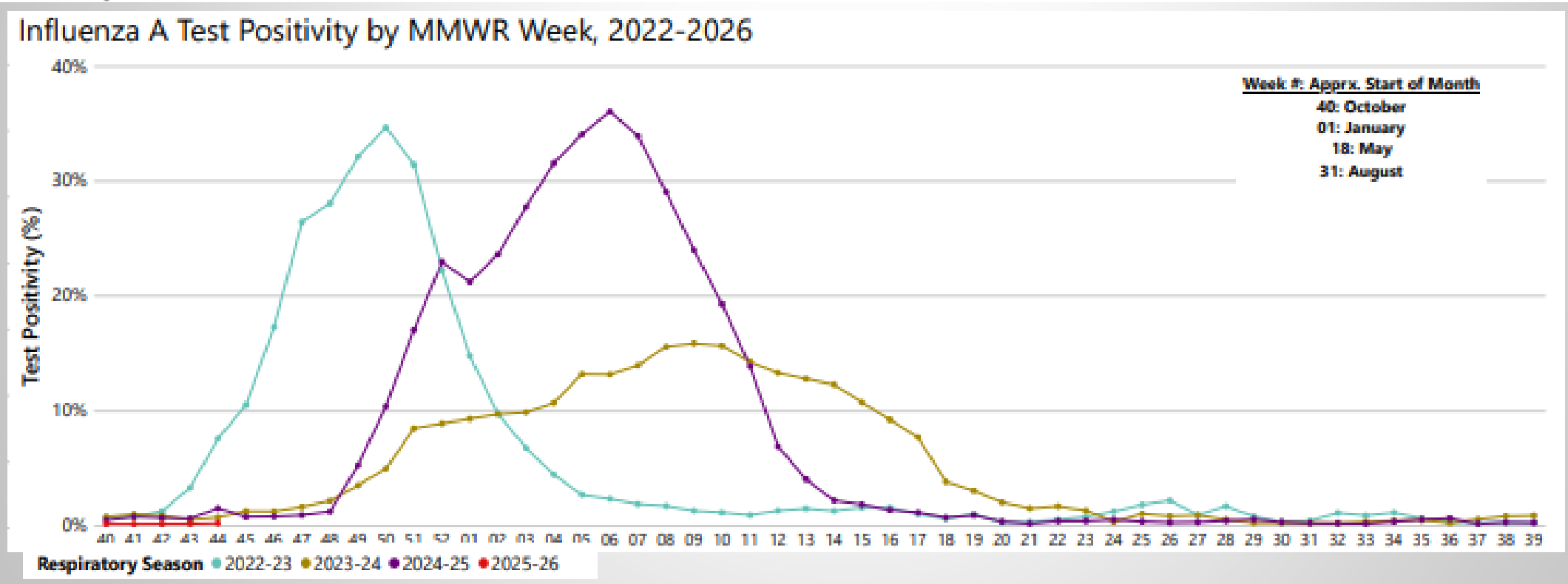
Positive Influenza A & B Tests, Test Positivity, and Changes from Last Week

Week Ending Date	Influenza A Positives	Change from Last Week	Influenza B Positives	Change from Last Week	Influenza Test Positivity	% Change from Last Week
11/1/2025	6	↑ 2	7	↑ 4	0.5%	↑ 0.2%
Season Total	**22**		**18**		**0.3%**	

https://dhhs.ne.gov/Flu%20Documents/Report.pdf

OUTBREAK SURVEILLANCE: 0 influenza-associated outbreaks have been reported in long-term care facilities during the 2025-26 surveillance season.

MORTALITY SURVEILLANCE: 0 influenza-associated deaths have been reported during the 2025-26 surveillance season.



COVID-19 (SARS-CoV-2) Surveillance Data, MMWR Week 44

All data are preliminary and may change as more reports are received. Data through week ending 11/1/2025

COVID-19 (SARS-CoV-2) WEEKLY SUMMARY

COVID-19 (SARS-CoV-2) LABORATORY SURVEILLANCE

Positive COVID-19 Tests, Test Positivity, and Changes from Last Week

Week Ending Date	COVID-19 Positives	Change from Last Week	Test Positivity	% Change from Last Week
11/1/2025	73	↑ 12	3.7%	↑ 0.3%
Season Total	**431**		**4.4%**	

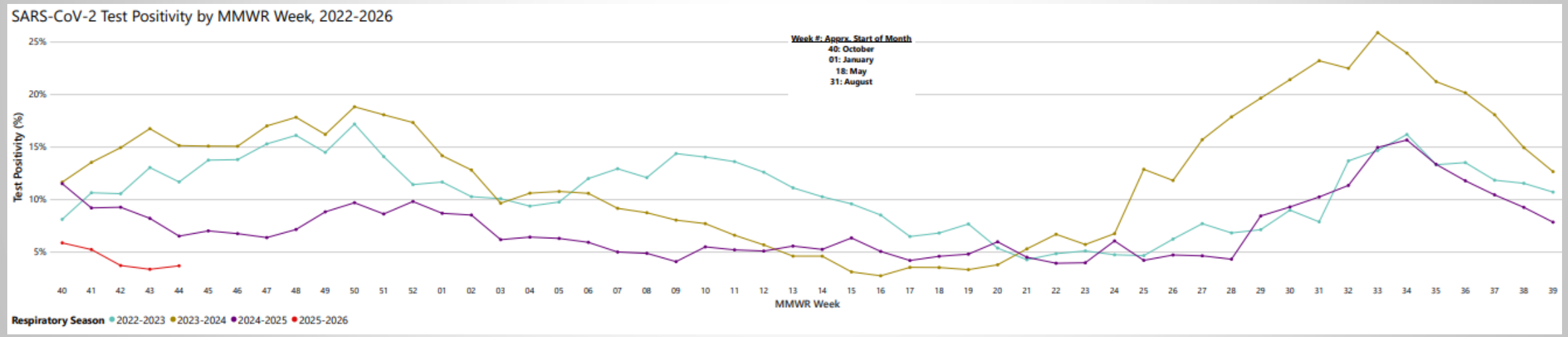
OUTBREAK SURVEILLANCE: 14 COVID-19 associated outbreaks have been reported in long-term care facilities during the 2025-26 surveillance season.

COVID-19 HOSPITALIZATION SURVEILLANCE

COVID-19 Hospitalizations and Change from Last Week

Week Ending Date	Total COVID-19 Hospitalizations	Change from Last Week
11/1/2025	11	↓ 4
Season Total	**83**	

MORTALITY SURVEILLANCE: <6 COVID-19 associated deaths have been reported during the 2025-26 surveillance season.



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COVID-19 (SARS-CoV-2) Surveillance Data, MMWR Week 44

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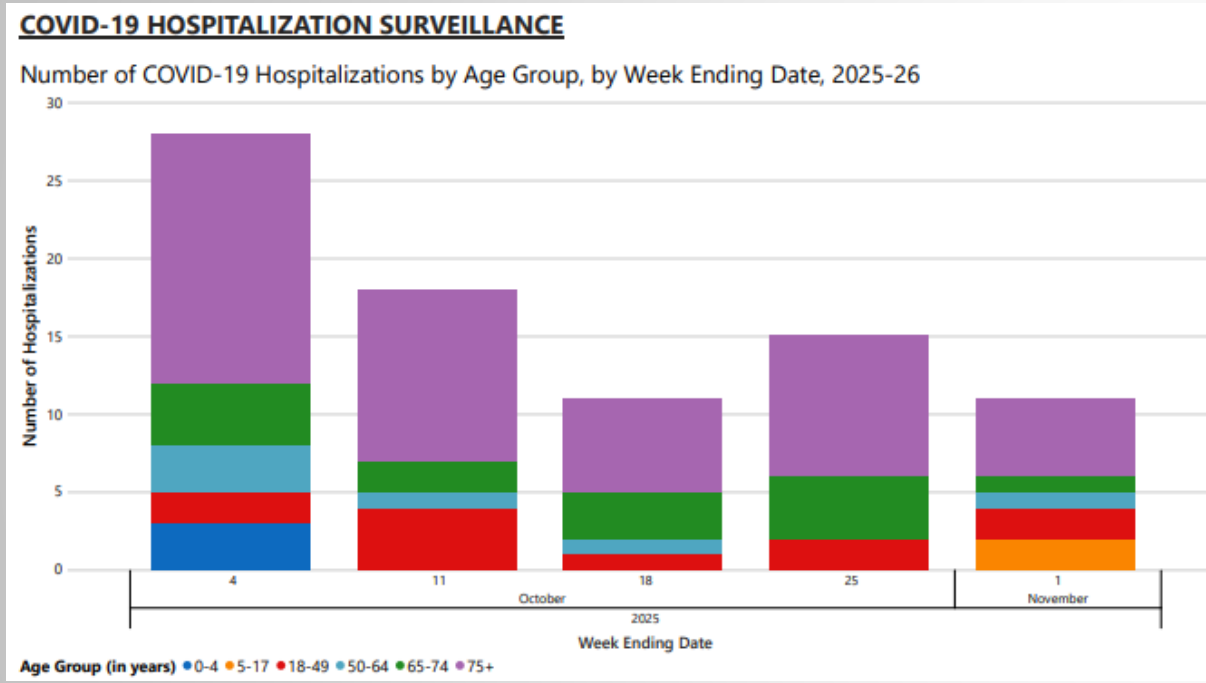
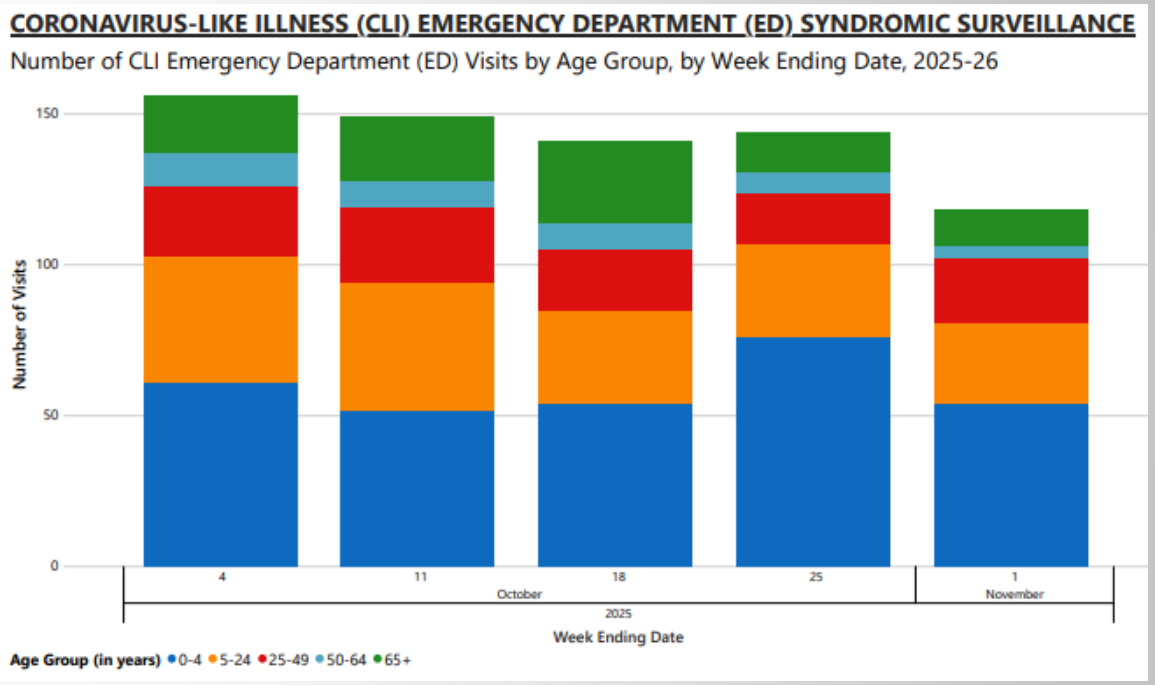
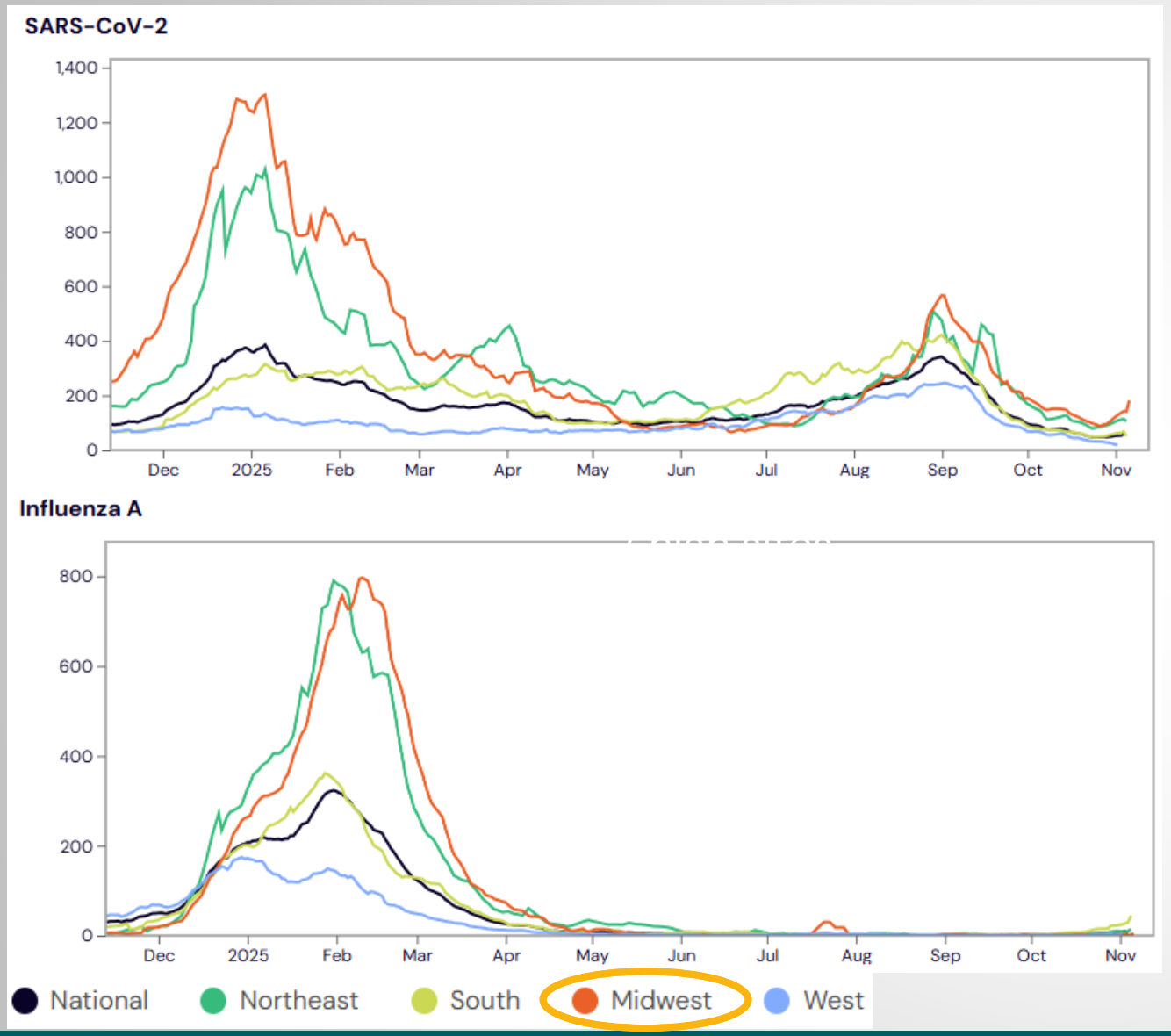




https://dhhs.ne.gov/Flu%20Documents/Report.pdf

COVID-19 Wastewater Data



SARS-CoV-2

High

Upward trend in the last 21 days and medium concentration

Influenza A

Low

Pathogen is seasonal and not in onset

WASTEWATER SCAN

https://www.wastewaterscan.org/en

Ages 19 Years or Older

Legend

- Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of immunity
- Recommended vaccination for adults with an additional risk factor or another indication
- Recommended vaccination based on shared clinical decision-making
- No Guidance/Not Applicable

Vaccine	19-26 years	27-49 years	50-64 years	≥65 years
COVID-19	1 or more doses of 2025–2026 vaccine (See Notes)			2 or more doses of 2025-2026 vaccine (See Notes)
Influenza inactivated (IIV3, ccIIV3) Influenza recombinant (RIV3)	1 dose annually			1 dose annually (HD–IIV3, RIV3, or aIIV3 preferred)
Influenza inactivated (aIIV3; HD–IIV3) Influenza recombinant (RIV3)	Solid organ transplant (See Notes)			
Influenza live, attenuated (LAIV3)	1 dose annually			
Respiratory Syncytial Virus (RSV)	Seasonal administration during pregnancy. (See Notes)		60 through 74 years (See Notes)	≥75 years

CDC Adult Immunization Schedule
https://www.cdc.gov/vaccines/hcp/imz-schedules/downloads/adult/adult-combined-schedule.pdf

CDC Underlying Conditions and Higher Risk for Severe COVID-19
https://www.cdc.gov/covid/hcp/clinical-care/underlying-conditions.html

ACIP Shared Clinical Decision Making
https://www.cdc.gov/acip/vaccine-recommendations/shared-clinical-decision-making.html

COVID–19 vaccination

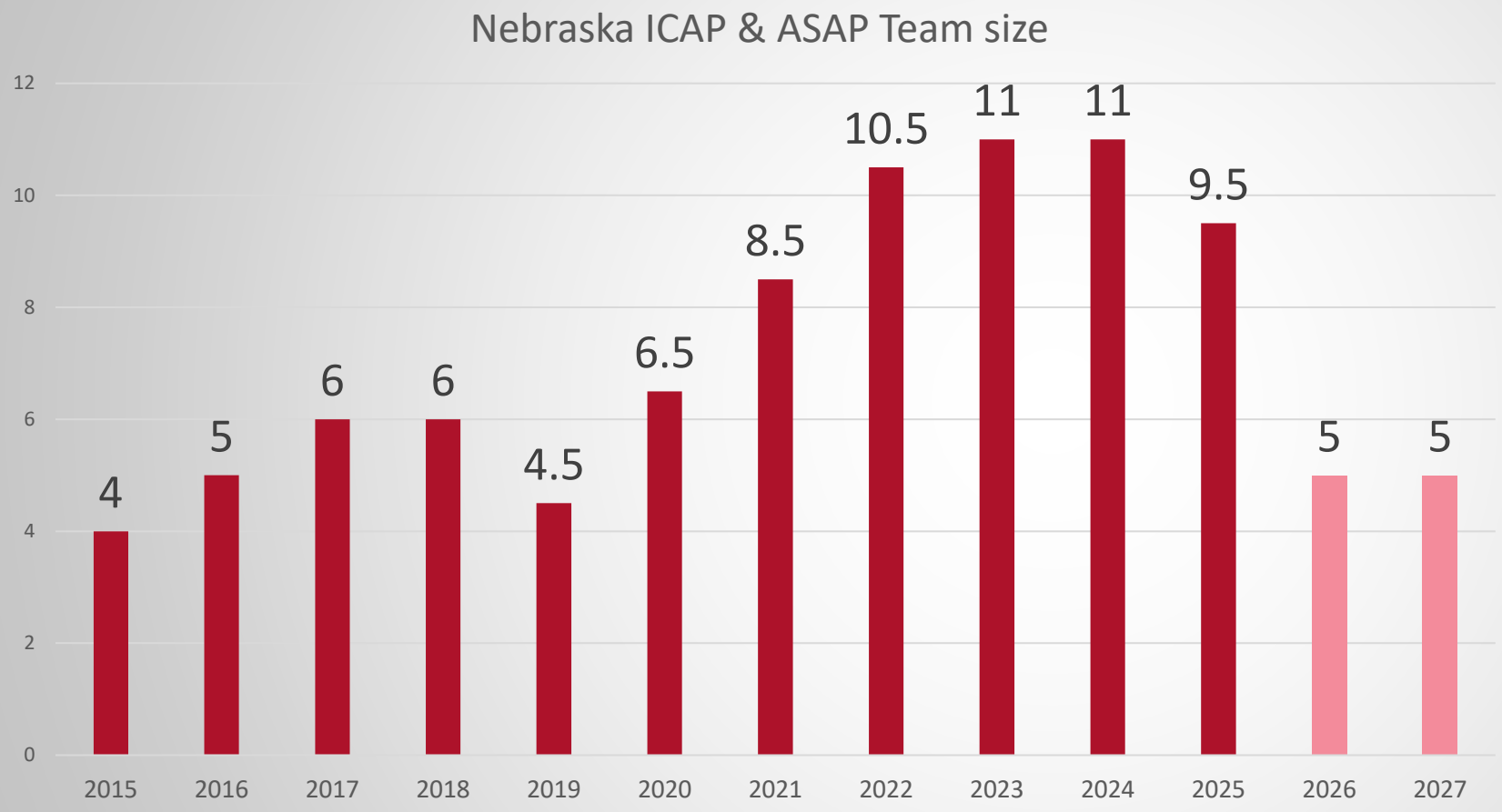
Shared clinical decision-making

Vaccination based on individual-based decision-making—with an emphasis that the risk-benefit of vaccination is most favorable for individuals who are at an increased risk for severe COVID-19 disease and lowest for individuals who are not at an increased risk according to the CDC list of COVID-19 risk factors (see www.cdc.gov/covid/hcp/clinical-care/underlying-conditions.html). For additional information on shared clinical decision-making, see www.cdc.gov/acip/vaccine-recommendations/shared-clinical-decision-making.html

Current COVID-19 schedule and dosage formulation available at www.cdc.gov/covidschedule.

Administer an age-appropriate COVID-19 vaccine product for each dose. There is no preferential recommendation for the use of one COVID-19 vaccine over another when more than one recommended age-appropriate vaccine is available.

Staffing Update at ICAP & ASAP



**Annual number does not include medical directors; 2026 & 2027 are based on projection*

Nebraska ASAP Infection and Antibiotic Use Tracking Tool

Jenna Preusker, PharmD, BCPS, BCIDP
ASAP Pharmacy Coordinator

NE ASAP

Next Week is US Antibiotic Awareness Week!

November 18-24, 2025

STATE OF NEBRASKA

Proclamation

WHEREAS, The Centers for Disease Control and Prevention has declared the week of November 18–24, 2025, as U.S. Antibiotic Awareness Week to promote the responsible use of antibiotics in communities, healthcare facilities, animal health, and agriculture, in collaboration with state-based program; and

WHEREAS, The Nebraska Department of Health and Human Services Healthcare-Associated Infections and Antimicrobial Resistance Program is dedicated to reducing antibiotic resistance, a serious and growing threat to public health; and

WHEREAS, The misuse and overuse of antibiotics contribute to the development of antibiotic resistance and increase the risk of complications such as Clostridioides difficile infections; and

WHEREAS, The observance of U.S. Antibiotic Awareness Week encourages patients to be "antibiotics aware" and supports prescribers, pharmacists, veterinarians, and other healthcare professionals in using antibiotics wisely.

NOW, THEREFORE, I, Jim Pillen, Governor of the State of Nebraska, DO HEREBY PROCLAIM the Week of November 18-24, 2025, as

ANTIBIOTIC AWARENESS WEEK

in Nebraska, and I do hereby urge all citizens to take due note of this observance.

IN WITNESS WHEREOF, I have hereunto set my hand and cause the Great Seal of the State of Nebraska to be affixed this Sixth Day of November, in the year of our Lord Two Thousand Twenty-Five.

Attest:

Secretary of State

Governor

New Resource!

LONG-TERM CARE ANTIBIOTIC STEWARDSHIP TOOLKIT

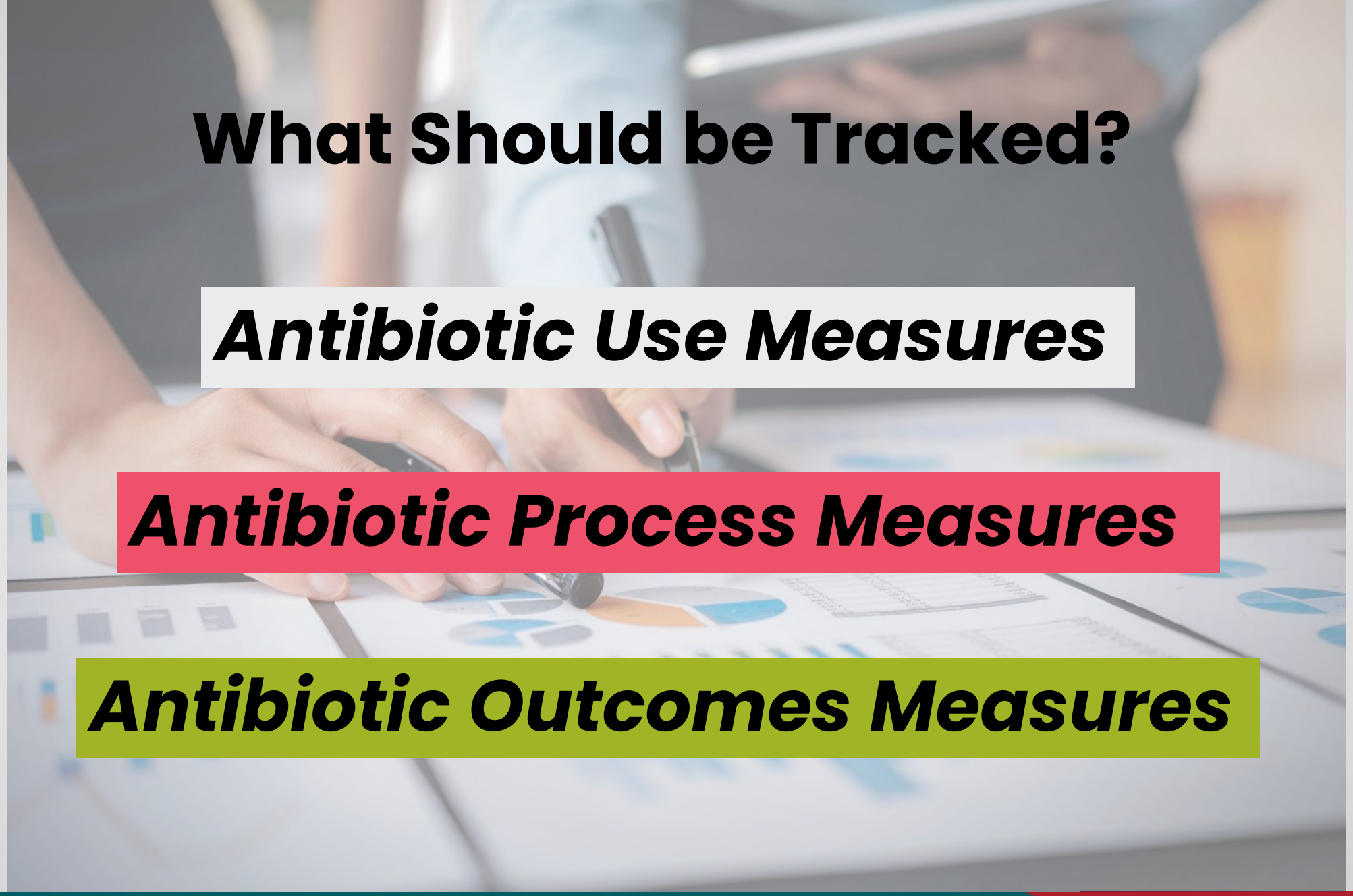
NEBRASKA ANTIMICROBIAL STEWARDSHIP ASSESSMENT AND PROMOTION PROGRAM ASAP

TABLE OF CONTENTS

Includes video trainings ideal for those new to antibiotic stewardship in LTC!

Link: Antibiotic Stewardship Toolkit - ASAP

ICAP



What Should be Tracked?

Antibiotic Use Measures

Antibiotic Process Measures

Antibiotic Outcomes Measures

What Should be Tracked?
Antibiotic Use Measures

- Antibiotic starts per 1000 resident-days
  - Antibiotic Drug and/or Class
- Days of therapy per 1000 resident-days
  - Can separate out prophylactic courses
- Infection type per 1000 resident-days
  - Can separate out prophylactic courses
- Prescriber name
- Rx origin (ED, clinic, hospital, LTCF)

Why Per 1000 Resident Days?

- Converts the number of starts, or days of therapy to a rate
  - Account for variations in number of residents and lengths of stay
  - Allow within facility comparison over time
  - Make between facility comparison possible

Calculation:

(# of antibiotic starts in August ÷ # of resident days August) X 1000

(# of days of therapy in August÷ # of resident days August) X 1000

Drugs That Typically are NOT Counted

- Antivirals
- Topical antifungals (powders or mouth rinses)
  - Nystatin, clotrimazole, ketoconazole
- Topical antibiotics
  - Triple antibiotic, bacitracin, mupirocin
- Antibiotic-containing eye and ear drops/ointments
  - Gentamicin, tobramycin, erythromycin, ciprofloxacin
- Inhaled antibiotics (usually tobramycin)
- Agents that work within GI tract or not absorbed
  - Sulfasalazine, rifaximin
  - Exceptions: vancomycin PO, fidaxomicin
- Urinary tract antiseptic/analgesic
  - Methenamine, phenazopyridine

Drugs That Typically ARE Counted

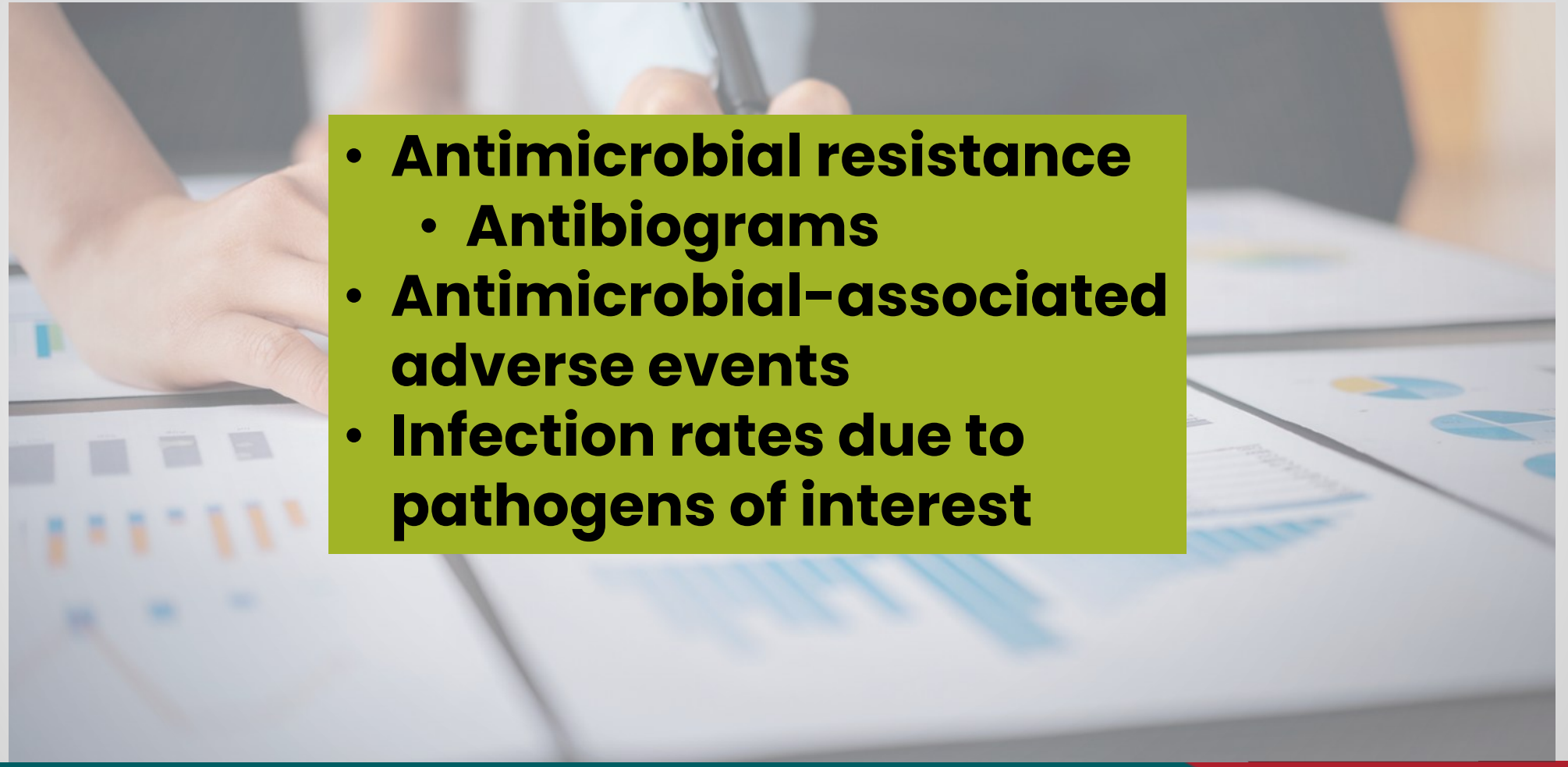
- Intravenous or intramuscular antibiotics
- Systemic antifungals (oral fluconazole)
- Antibiotics started outside of the LTCF
  - Primary care clinic
  - Urgent care
  - Emergency department
  - Hospital discharge
  - Facility transfers
  - Hospice
- Prophylactic (preventative) antibiotics
  - Chronic suppression (recurrent UTIs, osteomyelitis, or prosthetic joint infections)
  - Prior to dental, surgical, or urologic procedures if taken at the facility
  - Secondary prophylaxis (COPD exacerbations or recurrent cellulitis)

What Should be Tracked?
Antibiotic Process Measures

- Use of clinical assessment tool (SBAR)
  - Staff members performing assessment
- Loeb criteria met
- Antibiotic Reassessment (timeout) performed
- Antibiotic selection based on guidelines
- Surveillance definition met

What Should be Tracked?

Antibiotic Outcome Measures



- **Antimicrobial resistance**
  - **Antibiograms**
- **Antimicrobial-associated adverse events**
- **Infection rates due to pathogens of interest**

Tracking Outcome Measures – *Infection Rates of Specific Organisms*

- Resistant Pathogens and other Pathogens of Interest
  - MRSA (methicillin-resistant *Staphylococcus aureus*)
  - VRE (vancomycin-resistant enterococci)
  - ESBL (extended spectrum β-lactamase) Gram negative bacilli
  - CRE (carbapenem-resistant *Enterobacterales*)
  - Candida auris
  - *Clostridioides difficile* infections
- Data can be standardized by
  - Per **10,000** Resident-Days
  - Per number of new admissions
- Why track them?
  - Direct consequences of the extent of antibiotic use AND infection control practices

Other Outcome Measures – *Adverse Drug Events (ADR)*

- Rates of antibiotic-related adverse events
  - *C difficile* infections
  - Diarrhea, loose stools unrelated to CDI
  - Rash, hives
  - Fluoroquinolones: Tendon rupture, hypo/hyperglycemia, confusion, seizure, neuropathy, others
- Requires careful review of clinical records to determine causality
  - Naranjo adverse drug reaction probability scale
  - Classify causal relationship as definite, probable, possible, doubtful
- Request assistance from
  - Consultant pharmacist as part of monthly drug use evaluation
  - Medical director
  - Specific nurse caring for resident who experienced the ADR

Example of Tool for Evaluating ADR

[Facility Logo] | Resident Label

Adverse Drug Reaction Worksheet

Evaluation Date: _____ **Evaluated By:** _____ **Date of Adverse Reaction:** _____

Suspect Medication: _____ **Dosing Regimen:** _____ **Is medication new?** ☐ Yes ☐ No

Adverse Reaction: _____
(Refer to a list of common adverse antimicrobial reactions in Table 1 on the next page)

Probability Reaction Related to Medication (from the Naranjo Probability Scale below):

☐ Definite (≥ 9) ☐ Probable (5-8) ☐ Possible (1-4) ☐ Doubtful (0)

Consequence of Adverse Reaction (check all that apply):

☐ No change-therapy continued
☐ Increased monitoring
☐ Disability
☐ Hospitalization
☐ Therapy changed to another agent
☐ Symptomatic medical treatment
☐ Permanent Damage
☐ Other (specify): _____
☐ Therapy discontinued
☐ Corrective surgical procedure
☐ Delayed discharge

Reviewer: _____ **Date:** _____

Naranjo Adverse Drug Reaction Probability Scale (with modifications)

The following scale is used to assess the likelihood a particular adverse reaction is related to a medication. Answer each of the 10 questions, calculate total score, and determine if an adverse drug reaction is Definitely, Probably, Possibly, or unlikely related to the drug in question. *(Interpretation of the probability classification can be found in Table 2 on the next page)*

Question	Yes	No	Do Not Know	Score
1. Are there previous CONCLUSIVE reports on this reaction? *Answer yes if 2 or more well-described case reports can be found in the literature*	+1	0	0	
2. Did the adverse reaction appear after the suspected drug was administered? *Answer yes if reaction occurs in close temporal relation (e.g., within 1-2 days) after drug administration*	+2	−1	0	
3. Did the adverse reaction improve when the drug was discontinued or a specific antagonist given? *Answer yes if reaction lessens or disappears after the suspect drug stops or a pharmacologic antagonist given*	+1	0	0	
4. Did the adverse reaction reappear when the drug was readministered? *Answer yes if reaction disappears after drug discontinuation but reappear when the drug was restarted*	+2	−1	0	
5. Are there alternative causes (other than the suspect drug) that could have caused the reaction? *Answer yes if the reaction can be explained by causes or medications other than the suspect drug*	−1	+2	0	
6. Did the reaction reappear when a placebo was given? *Answer yes if the reaction reappears after administration a placebo*	−1	+1	0	
7. Was the drug detected in blood or other fluids in concentrations known to be toxic? *Answer yes if drug concentration is in the toxic or supratherapeutic range*	+1	0	0	
8. Was the reaction more severe when dose was increased or less severe when dose was decreased? *Answer yes if the intensity of the reaction is stronger with higher dose or weaker with lower dose*	+1	0	0	
9. Did the patient have a similar reaction to the same or similar drugs in any previous exposure? *Answer yes if patient has a similar documented reaction when exposed to the suspect drug or related medication in the past*	+1	0	0	
10. Was the adverse reaction confirmed by any objective evidence? *Answer yes if the reaction can be confirmed by abnormal lab values, imaging, or physical examination*	+1	0	0	
		Total Score		

Table 1. List of Common Adverse Antimicrobial Reactions*

Drug Class	Class Member	Common Adverse Reaction
Penicillins +/- Beta-Lactamase inhibitors	Ampicillin, Ampicillin-Sulbactam, Amoxicillin, Amoxicillin-Clavulanate, Cloxacillin, Dicloxacillin, Nafcillin, Oxacillin, Penicillin, Piperacillin-Tazobactam	Nausea, vomiting, diarrhea, *C difficile* infection, allergic reactions (including rash, hemolytic anemia), elevated serum creatinine, bone marrow suppression with long-term use, phlebitis with IV therapy
Cephalosporins +/- Beta-Lactamase Inhibitors	Cefaclor, Cefazolin, Cefdinir, Cefditoren, Cefepime, Cefixime, Cefotetan, Cefoxitin, Cefpodoxime, Cefprozil, Ceftaroline, Ceftazidime, Ceftazidime-Avibactam, Ceftibuten, Ceftolozane-Tazobactam, Ceftriaxone, Cefuroxime, Cephadroxil, Cephalexin	Nausea, vomiting diarrhea, *C difficile* infection, allergic reactions (including rash, serum sickness), altered mental status
Carbapenems	Doripenem, Ertapenem, Imipenem-Cilastatin, Meropenem	Nausea, vomiting, diarrhea, *C difficile* infection, seizure
Fluoroquinolones	Ciprofloxacin, Delafloxacin Levofloxacin, Moxifloxacin	Disorientation, delirium, agitation, seizure, hypo- or hyper-glycemia, peripheral neuropathy, tendon rupture, QT prolongation, nausea, vomiting, *C difficile* infection, increased in liver function tests, aortic dissection
Macrolides	Azithromycin, Clarithromycin, Erythromycin	Nausea, vomiting, elevation in liver function tests, reversible tinnitus or deafness, taste alteration, phlebitis with IV therapy
Tetracyclines	Doxycycline, Minocycline, Tetracycline	Nausea, vomiting, sunburn, esophageal ulcer, phlebitis with IV therapy, teeth discoloration
Sulfonamides	Sulfamethoxazole-Trimethoprim	Allergic reactions (rash, hives, drug fever, Steven Johnson Syndrome), headache, sunburn, hyperkalemia, worsen renal functions, bone marrow suppression, hemolytic anemia, hypoglycemia (especially with sulfonylureas)
Glycopeptides	Telavancin, Vancomycin IV	Redman syndrome (flushing, itching, hypotension), worsened renal functions
Others	Clindamycin, Metronidazole, Nitrofurantoin	All: Nausea, vomiting; Clindamycin: diarrhea, *C difficile* infection, taste alteration; Metronidazole: disulfiram reaction after alcohol (flushing, dyspnea), taste alteration, peripheral neuropathy, confusion; Nitrofurantoin: interstitial pneumonitis especially with chronic use, hemolytic anemia

* The above list does not include all antimicrobials or all adverse drug reactions. Consult drug references and published literature for additional information if an adverse drug reaction not listed above is suspected.

Table 2. Interpretation of Probability Categories

Category	Score Range	Interpretation
Definite	≥ 9	Reaction 1) followed a reasonable temporal sequence after a drug or in which a toxic drug level had been established in body fluids or tissues; 2) followed a recognized response to the suspected drug; and 3) was confirmed by withdrawal but not by exposure to the drug
Probably	5 – 8	Reaction 1) followed a reasonable temporal sequence after a drug; 2) followed a recognized response to the suspected drug; 3) was confirmed by withdrawal but not by exposure to the drug; 4) could not be reasonably explained by the known characteristics of the patient's clinical state
Possible	1 – 4	Reaction 1) followed a temporal sequence after a drug; 2) possibly followed a recognized pattern to the suspected drug; 3) could be explained by characteristics of the patient's disease
Doubtful	0	Reaction was likely related to factors other than a drug

Reference
Naranjo CA, *et al*. A method for estimating the probability of adverse drug reactions. Clin Pharmacol Ther 1981:30:239-45.

https://asap.nebraskamed.com/long-term-care/tools-templates-long-term-care/

Reporting Data

Reporting Antimicrobial Stewardship Data Activities and Outcomes

- CDC recommends reporting tracked data to:
  - Clinical providers
  - Nursing staff
- Optional: selective data to residents/families

What good is it if no one knows about it!

- Data can increase buy-in
- Resistance rate may deter use
- Rate of inappropriate UA/culture may improve use of assessment tool
- Justify your time and efforts in the facility

Reporting Antimicrobial Stewardship Activities and Outcomes

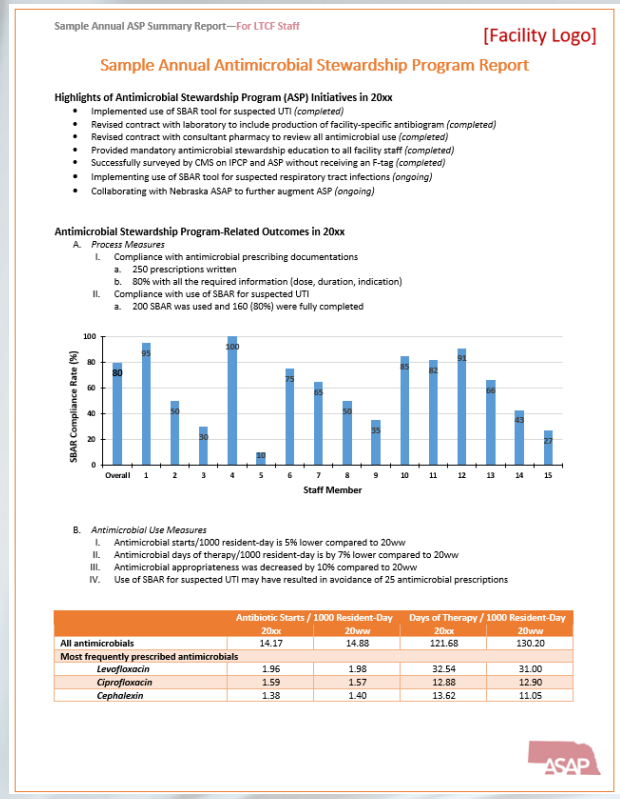
What to report

- Antibiotic use data (starts, DOT)
- Rates of specific infections
- Interventions (actions) made and any outcomes
- Compliance to policy (met criteria before starting antibiotics)
- Outlier data

How to report

- Use existing system
  - Newsletter, QAPI report, posters, prescriber letters
- Frequency varies based on type of information
  - Annually for antibiogram, antibiotic spending
  - Quarterly, semi-annually, or annually for other info such as intervention outcomes

Report Out Templates



Sample Annual ASP Summary Report—For LTCF Staff

[Facility Logo]

Sample Annual Antimicrobial Stewardship Program Report

Highlights of Antimicrobial Stewardship Program (ASP) Initiatives in 20xx

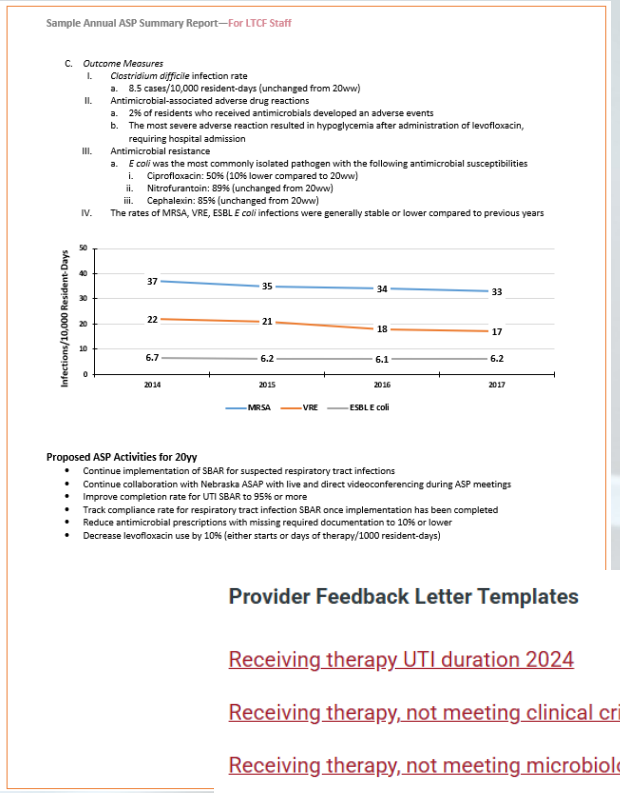
- Implemented use of SBAR tool for suspected UTI *(completed)*
- Revised contract with laboratory to include production of facility-specific antibiogram *(completed)*
- Revised contract with consultant pharmacy to review all antimicrobial use *(completed)*
- Provided mandatory antimicrobial stewardship education to all facility staff *(completed)*
- Successfully surveyed by CMS on IPCP and ASP without receiving an F-tag *(completed)*
- Implementing use of SBAR tool for suspected respiratory tract infections *(ongoing)*
- Collaborating with Nebraska ASAP to further augment ASP *(ongoing)*

Antimicrobial Stewardship Program-Related Outcomes in 20xx

A. *Process Measures*
   I. Compliance with antimicrobial prescribing documentations
      a. 250 prescriptions written
      b. 80% with all the required information (dose, duration, indication)
   II. Compliance with use of SBAR for suspected UTI
      a. 200 SBAR was used and 160 (80%) were fully completed

B. *Antimicrobial Use Measures*
   I. Antimicrobial starts/1000 resident-day is 5% lower compared to 20ww
   II. Antimicrobial days of therapy/1000 resident-day is by 7% lower compared to 20ww
   III. Antimicrobial appropriateness was decreased by 10% compared to 20ww
   IV. Use of SBAR for suspected UTI may have resulted in avoidance of 25 antimicrobial prescriptions

	Antibiotic Starts / 1000 Resident-Day		Days of Therapy / 1000 Resident-Day	
	20xx	20ww	20xx	20ww
All antimicrobials	14.17	14.88	121.68	130.20
Most frequently prescribed antimicrobials				
Levofloxacin	1.96	1.98	32.54	31.00
Ciprofloxacin	1.59	1.57	12.88	12.90
Cephalexin	1.38	1.40	13.62	11.05



Sample Annual ASP Summary Report—For LTCF Staff

C. *Outcome Measures*
   I. *Clostridium difficile* infection rate
      a. 8.5 cases/10,000 resident-days (unchanged from 20ww)
   II. Antimicrobial-associated adverse drug reactions
      a. 2% of residents who received antimicrobials developed an adverse events
      b. The most severe adverse reaction resulted in hypoglycemia after administration of levofloxacin, requiring hospital admission
   III. Antimicrobial resistance
      a. *E coli* was the most commonly isolated pathogen with the following antimicrobial susceptibilities
         i. Ciprofloxacin: 50% (10% lower compared to 20ww)
         ii. Nitrofurantoin: 89% (unchanged from 20ww)
         iii. Cephalexin: 85% (unchanged from 20ww)
   IV. The rates of MRSA, VRE, ESBL *E coli* infections were generally stable or lower compared to previous years

Proposed ASP Activities for 20yy

- Continue implementation of SBAR for suspected respiratory tract infections
- Continue collaboration with Nebraska ASAP with live and direct videoconferencing during ASP meetings
- Improve completion rate for UTI SBAR to 95% or more
- Track compliance rate for respiratory tract infection SBAR once implementation has been completed
- Reduce antimicrobial prescriptions with missing required documentation to 10% or lower
- Decrease levofloxacin use by 10% (either starts or days of therapy/1000 resident-days)

Provider Feedback Letter Templates

Receiving therapy UTI duration 2024

Receiving therapy, not meeting clinical criteria, catheterized 2024

Receiving therapy, not meeting microbiologic criteria, or non-susceptible organism, catheterized 2024

Receiving therapy, not meeting microbiologic criteria, or non-susceptible organism, uncatheterized 2024

Receiving therapy, not meeting clinical criteria, uncatheterized 2024

Therapy completed, not meeting clinical criteria, catheterized 2024

Therapy completed, not meeting clinical criteria, uncatheterized 2024

Therapy completed, not meeting microbiologic criteria, catheterized 2024

Therapy completed, not meeting microbiologic criteria, uncatheterized 2024

Therapy completed, UTI duration 2024

Link: Tools and Templates for Long Term Care - ASAP

Turning Reported Data Into Action

Low compliance with prescription documentation

- Provider education
- Policy to enforce or reinforce compliance
- If verbal order, implement process to obtain all required information

Low compliance with assessment or SBAR tool use

- Nursing staff education
- One-on-one feedback
- Evaluate ease-of-use of tools

High rates of infections

- Discuss with Infection Preventionist
- Examine infection control practices
- Review urinary catheter cares, wound cares, peri cares, etc.

Slide credit: Alex Neukirch, PharmD
Consultant Pharmacist, Consonus Pharmacy

High rates of hospitalization

- Examine reasons: infectious vs. non-infectious causes
- If infectious:
  - Review antibiotic request, med administration procedures
  - Review empiric antibiotic use
  - Review adverse event rates

High rates of use in certain classes of antibiotics

- Antibiotic classes may become a target for improvement (e.g., fluoroquinolones)
- Antibiotic agents used for the treatment of specific infections (e.g., *C. difficile* or UTIs)

High resistance rates for certain antibiotics

- Review use of the antibiotic in question
  - Remove antibiotic from any facility guidelines

Location of antibiotic initiation

- Prescriber education
- Encourage antibiotic reassessments/timeouts
- Engage referring hospitals and emergency departments

Slide credit: Alex Neukirch, PharmD
Consultant Pharmacist, Consonus Pharmacy

High Frequency of antibiotic starts not meeting criteria

- Nursing education on tools
- Prescriber education on appropriate criteria
- Medical director involvement if necessary

Duration of therapy longer than necessary

- Prescriber education
- Facility treatment guidelines
- Implement antibiotic time-out tool
- Medical director involvement if necessary

High rate of bug-drug mismatch

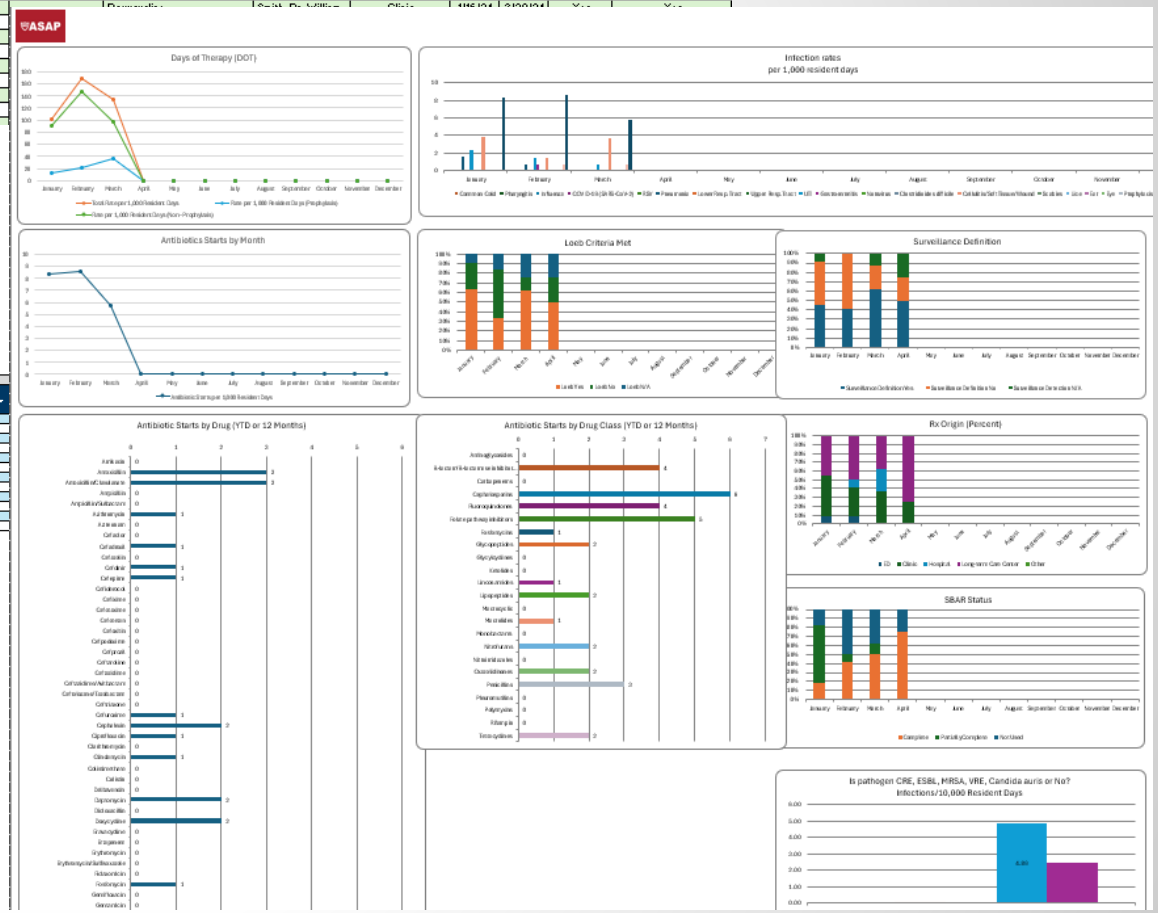
- Prescriber education on antibiogram
- Facility treatment guidelines

Slide credit: Alex Neukirch, PharmD
Consultant Pharmacist, Consonus Pharmacy

Demonstration of Nebraska ASAP Infection and Antibiotic Tracking Tool

Note: Fictitious data for illustration purposes only

Resident Information			Classification		History					Diagnostics (microbiology, other labs, radiology)				Antimicrobial Starts					
Unit Name	Resident Name	Room #	Infection type	Surveillance definition met?	Symptom(s)	Symptom Onset	Device Type	Date of last	Date of Res	Test Date	Type of Test	Specimen Source	Results (Organism colony count)	Is the pathogen MDRO?	Antibiotic Name	Provider	Antimicrobial Rx Origin	Antibiotic Start	Antibiotic End	Loeb Criteria Met	Antibiotic Reassessment (Antibiotic Time Out)
1		102	Prophylaxis - Skin	Yes	warmth, drainage	1/16/24	No Devices					No Culture Taken									
2		222	UTI	No	lethargic,fever, AMS	1/17/24	No Devices					No Culture Taken									
3		114	UTI	Yes	repeat fall, AMS, hematuria	1/26/24	No Devices			1/26/24		Urine	E. Coli								
4		100	Cellulitis/Soft Tissue/Wound	No	warmth, swelling, redness, wounds	1/16/24	No Devices					No Culture Taken									
5		201	Cellulitis/Soft Tissue/Wound	No	warmth, drainage	1/10/24	No Devices					No Culture Taken									
6		210	Cellulitis/Soft Tissue/Wound	Yes	warmth, drainage	1/16/24	No Devices					No Culture Taken									
7		306	Cellulitis/Soft Tissue/Wound	No	warmth, swelling, redness, wounds	1/16/24	No Devices					No Culture Taken									
8		103	UTI	Yes	repeat fall, AMS	1/26/24	No Devices			1/26/24		Urine	E. Coli								
9		211	Pneumonia	N/A	temp, malaise, cough	1/30/24	No Devices					No Culture Taken									
9		211	Pneumonia	Yes	fe																
10		106	Cellulitis/Soft Tissue/Wound	No	re																
11		301	Pneumonia	No	co																
14		212	Upper Resp. Tract	Yes	ma																
15		211	Cellulitis/Soft Tissue/Wound	Yes	wa																
16		111	Cellulitis/Soft Tissue/Wound	No	re																
17		301	Upper Resp. Tract	No	cl																
18		206	Upper Resp. Tract	Yes	co																
13		103	Gastroenteritis	Yes	di																
21		110	UTI	Yes	fr																
22		111	Upper Resp. Tract	No	co																
23		120	Other	No	ac																
24		203	Upper Resp. Tract	No	cl																
25		207	UTI	No	in																
26		128	Prophylaxis - UTI	No	re																
27		130	UTI	Yes	dy																
28		205	Influenza	Yes	fe																
29		101	Cellulitis/Soft Tissue/Wound	Yes	ms																
30		102	Cellulitis/Soft Tissue/Wound	Yes	re																
31		219	Cellulitis/Soft Tissue/Wound	Yes	wa																
32		206	Cellulitis/Soft Tissue/Wound	No	re																
33		113	Other	N/A	os																
34		115	Cellulitis/Soft Tissue/Wound	Yes	wo																
35		207	UTI	Yes	fe																
36		110	Gastroenteritis	N/A	di																
37		205	Cellulitis/Soft Tissue/Wound	Yes	ms																
38		206	Cellulitis/Soft Tissue/Wound	No	re																



[Link: Tools and Templates for Long Term Care - ASAP]

Nebraska ASAP Antibiotic Tracking Tool – FAQs

Q: What if a resident has more than one antibiotic for the same infection?

To accurately document antibiotic use in this situation, there should be a separate record/row for each antibiotic with the resident name (and associated resident information) replicated for each entry.

Individual records for each antibiotic allow for different start/end days. Also, because this resident has a single infection, only include the Infection Type on the first entry; the Infection Type should be blank for the related entries. This will provide accurate count of the net number of infections.

Q: What if a resident has different antibiotics for different infections?

A unique antibiotic for a resident always results in a new record/row. In this example, the resident had antibiotic A for infection #1 and antibiotic B for infection #2, so two records would be entered.

Find the Full ASAP Tracking Tool Instructions and FAQ Here!

Nebraska ASAP Antibiotic Tracking Tool – FAQs

Q: How do I document and generate updated tables and charts when a resident has an antibiotic from one month to the next (January 25 to February 12 as an example)?

A resident with an antibiotic from one month to the next is only entered on one line. You can leave the Antibiotic End Date blank until the completion of the antibiotic course.

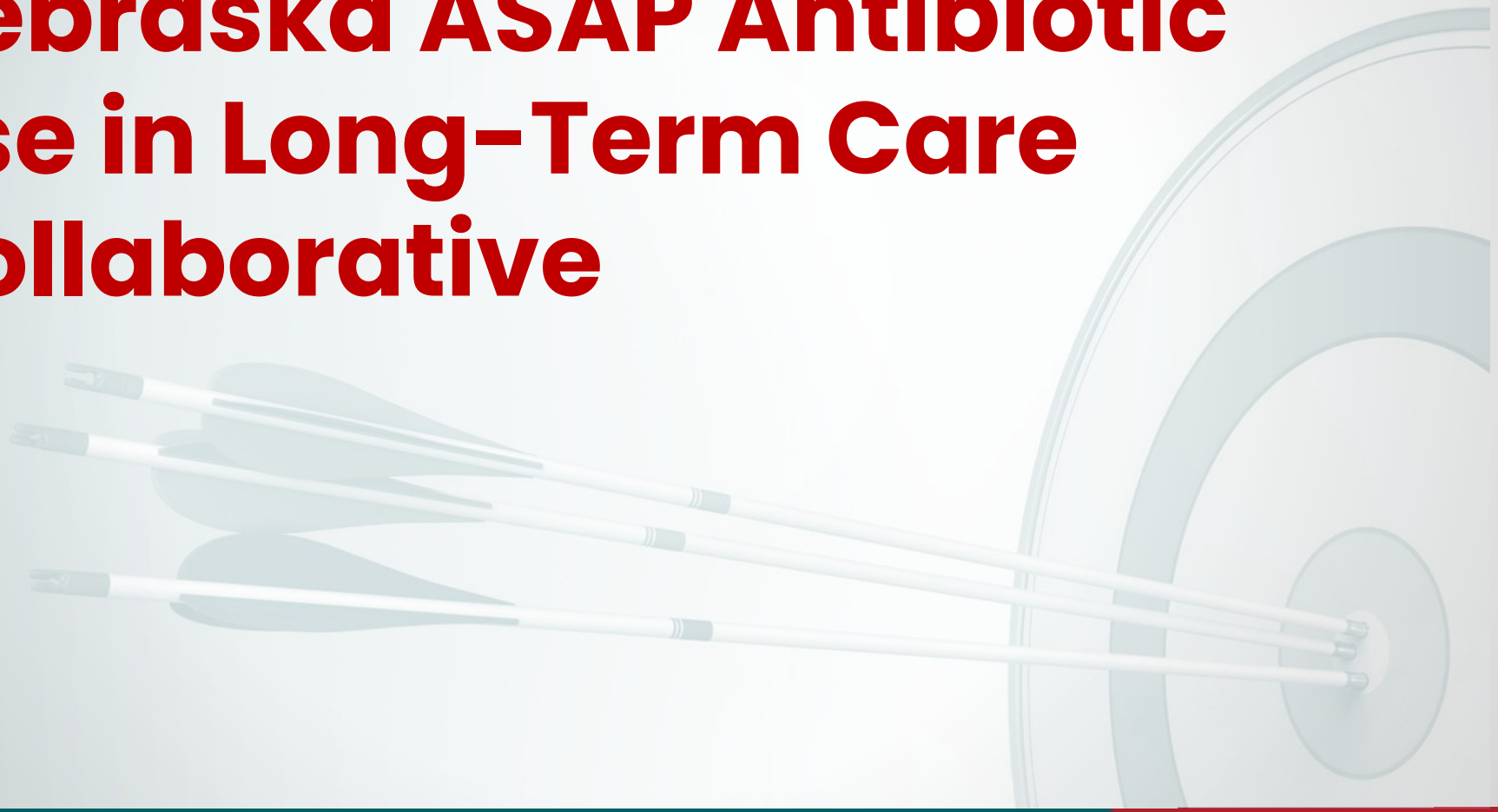
Monthly tables and graphs will not be complete until antibiotic start and end dates are entered. If tables and graphs for the previous month are required, consider entering the last date of the previous month as the Antibiotic End Date for these specific entries. Consider including a note in the Comments field so you can more easily identify and update these entries after the completion of each antibiotic course.

Q: This Tracker is for a calendar year – how do I document data for next year?

We recommend archiving the workbook at the end of each calendar year and beginning to enter data into a new, blank workbook for the new calendar year.

Establishing a process to archive data is a good practice to preserve valuable information for long-term retention which ensures accessibility for future reference, research, and compliance. Consider copying the data or saving the entire workbook in a secure location as per your company guidelines.

Nebraska ASAP Antibiotic Use in Long-Term Care Collaborative



Antibiotic Use Collaborative Database for Nebraska LTCF

- An opportunity is available for Nebraska LTCF to collaborate with antimicrobial stewardship experts through the Nebraska ASAP program
- The aim of the Nebraska ASAP LTCF Antibiotic Use Tracking Collaborative is to provide participating LTCFs with both **facility-specific** and **benchmarked** antibiotic use information to guide their initiatives
- There are currently 40 LTCF enrolled in the database

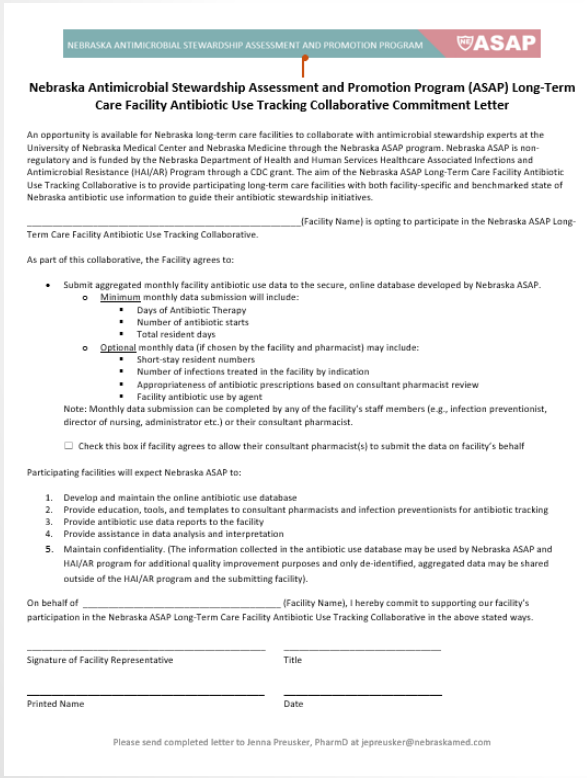
How to Participate

Step 1:

- Click Here to Sign the Commitment Letter

AND

- Email Jenna (jepreusker@nebraskamed.com)



NEBRASKA ANTIMICROBIAL STEWARDSHIP ASSESSMENT AND PROMOTION PROGRAM ASAP

Nebraska Antimicrobial Stewardship Assessment and Promotion Program (ASAP) Long-Term Care Facility Antibiotic Use Tracking Collaborative Commitment Letter

An opportunity is available for Nebraska long-term care facilities to collaborate with antimicrobial stewardship experts at the University of Nebraska Medical Center and Nebraska Medicine through the Nebraska ASAP program. Nebraska ASAP is non-regulatory and is funded by the Nebraska Department of Health and Human Services Healthcare Associated Infections and Antimicrobial Resistance (HAI/AR) Program through a CDC grant. The aim of the Nebraska ASAP Long-Term Care Facility Antibiotic Use Tracking Collaborative is to provide participating long-term care facilities with both facility-specific and benchmarked state of Nebraska antibiotic use information to guide their antibiotic stewardship initiatives.

_____(Facility Name) is opting to participate in the Nebraska ASAP Long-Term Care Facility Antibiotic Use Tracking Collaborative.

As part of this collaborative, the Facility agrees to:

- Submit aggregated monthly facility antibiotic use data to the secure, online database developed by Nebraska ASAP.
  - Minimum monthly data submission will include:
    - Days of Antibiotic Therapy
    - Number of antibiotic starts
    - Total resident days
  - Optional monthly data (if chosen by the facility and pharmacist) may include:
    - Short-stay resident numbers
    - Number of infections treated in the facility by indication
    - Appropriateness of antibiotic prescriptions based on consultant pharmacist review
    - Facility antibiotic use by agent

  Note: Monthly data submission can be completed by any of the facility's staff members (e.g., infection preventionist, director of nursing, administrator etc.) or their consultant pharmacist.

  ☐ Check this box if facility agrees to allow their consultant pharmacist(s) to submit the data on facility's behalf

Participating facilities will expect Nebraska ASAP to:

1. Develop and maintain the online antibiotic use database
2. Provide education, tools, and templates to consultant pharmacists and infection preventionists for antibiotic tracking
3. Provide antibiotic use data reports to the facility
4. Provide assistance in data analysis and interpretation
5. Maintain confidentiality. (The information collected in the antibiotic use database may be used by Nebraska ASAP and HAI/AR program for additional quality improvement purposes and only de-identified, aggregated data may be shared outside of the HAI/AR program and the submitting facility).

On behalf of _____ (Facility Name), I hereby commit to supporting our facility's participation in the Nebraska ASAP Long-Term Care Facility Antibiotic Use Tracking Collaborative in the above stated ways.

_____ _____
Signature of Facility Representative Title

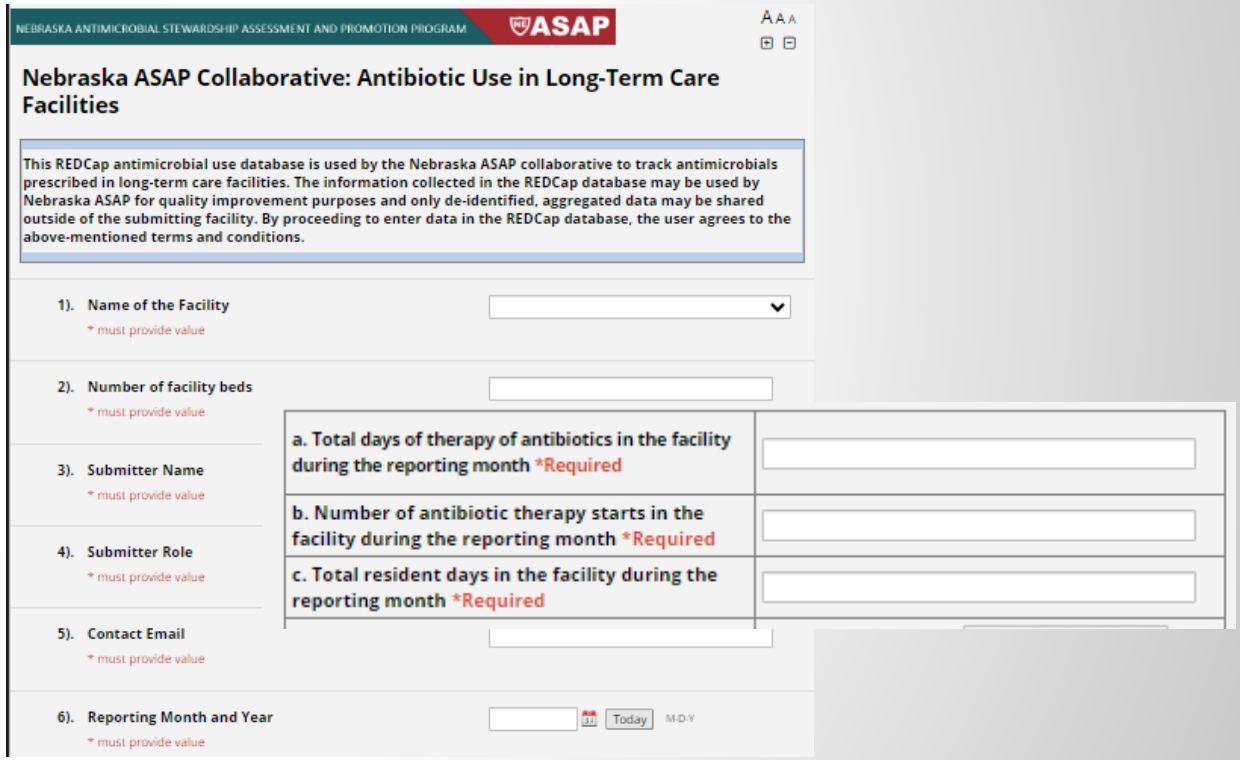
_____ _____
Printed Name Date

Please send completed letter to Jenna Preusker, PharmD at jepreusker@nebraskamed.com

Step 2:

Nebraska ASAP will email you a link each month to enter 3 data points.

- **Total days of antibiotic therapy**
- **Number of antibiotic starts**
- **Total resident days**



NEBRASKA ANTIMICROBIAL STEWARDSHIP ASSESSMENT AND PROMOTION PROGRAM ASAP

Nebraska ASAP Collaborative: Antibiotic Use in Long-Term Care Facilities

This REDCap antimicrobial use database is used by the Nebraska ASAP collaborative to track antimicrobials prescribed in long-term care facilities. The information collected in the REDCap database may be used by Nebraska ASAP for quality improvement purposes and only de-identified, aggregated data may be shared outside of the submitting facility. By proceeding to enter data in the REDCap database, the user agrees to the above-mentioned terms and conditions.

1). Name of the Facility
* must provide value

2). Number of facility beds
* must provide value

3). Submitter Name
* must provide value

4). Submitter Role
* must provide value

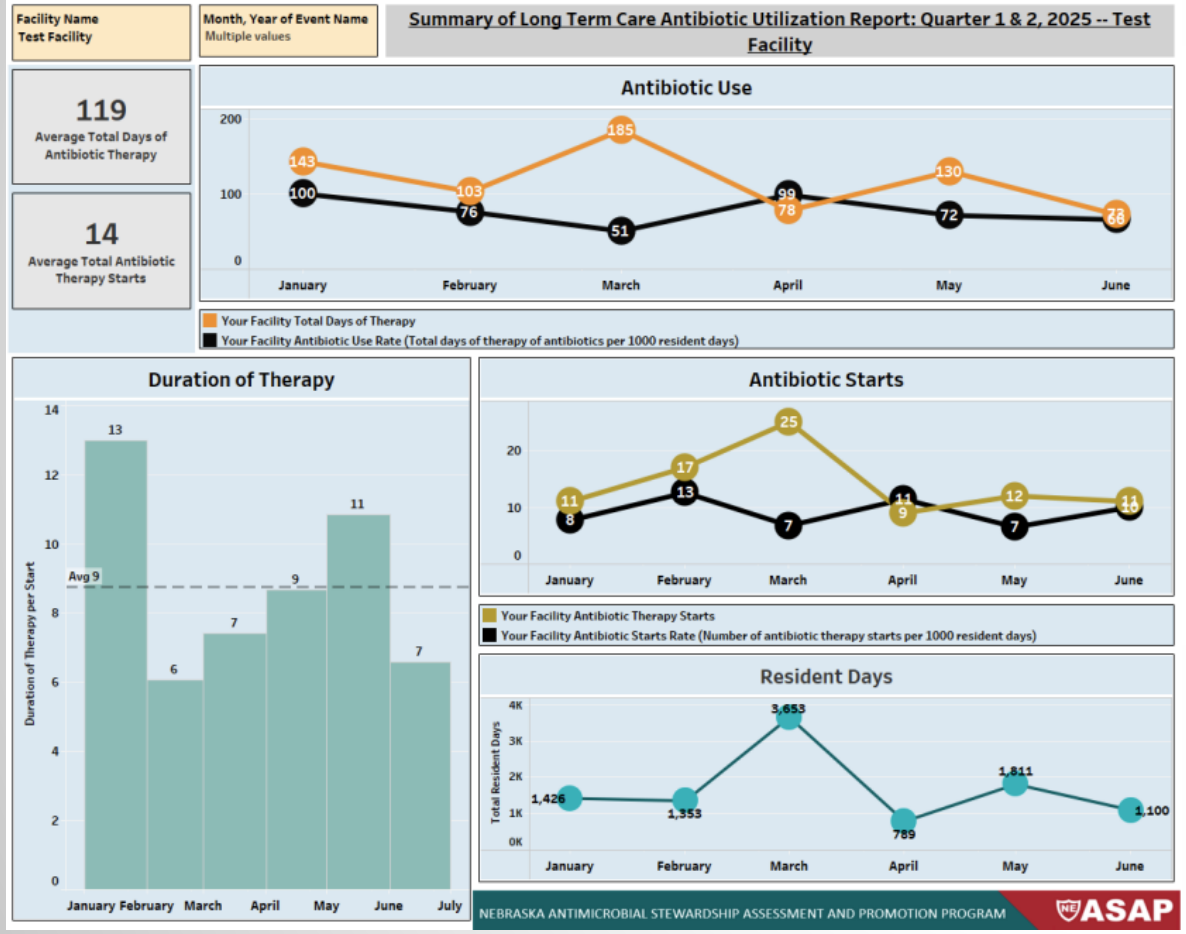
5). Contact Email
* must provide value

6). Reporting Month and Year
* must provide value
Today M-D-Y

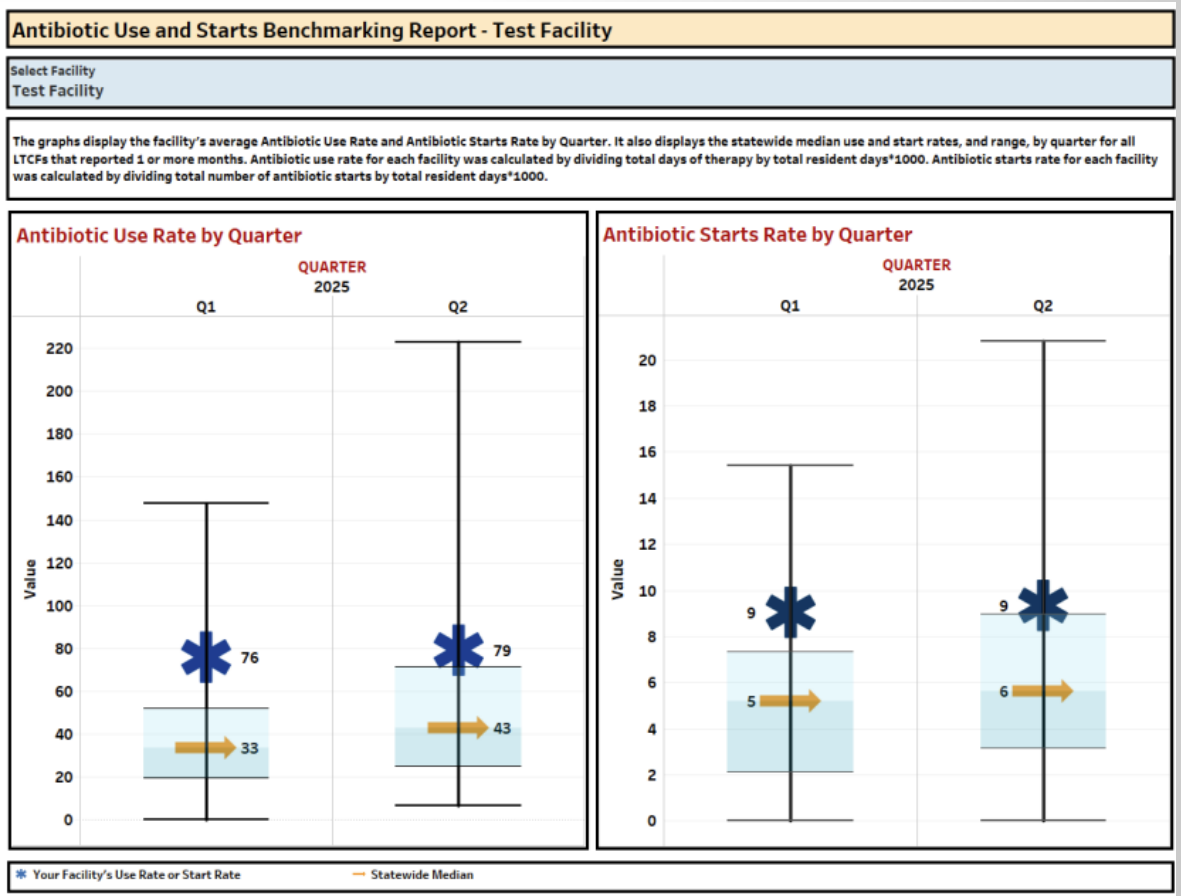
a. Total days of therapy of antibiotics in the facility during the reporting month *Required	
b. Number of antibiotic therapy starts in the facility during the reporting month *Required	
c. Total resident days in the facility during the reporting month *Required	

Sample Quarterly LTC Antibiotic Use report:

Facility Level Data – Page 1



Comparative Data – Page 2



ICAP

In Closing

NE ICAP

CDC's Project Firstline Partner Resource Reminder

Talking with patients about antibiotic use

1. Deliver a clear diagnosis that explains why antibiotics are not needed.
2. Utilize positive treatment recommendations.
3. Develop contingency plans.
4. Delay antibiotic prescriptions.

Poster/Handout Link

New Webpage of Resources for ALL Healthcare Settings

Resources for ALL Healthcare Settings

CDC

- CDC Guidelines and Guidance Library
- CDC National Healthcare Safety Network (NHSN)
- CDC Project Firstline*
- CDC Water Management Toolkit

Our Recommended Resources

- American Society for Health Care Engineering (ASHE) ICRA 2.0 Toolkit
- APIC
- CSTE Water Management Program (WMPs) Evaluation Tool
- Environmental Protection Agency (EPA) Selected EPA-Registered Disinfectants
- Immunize.org
- Nebraska Antimicrobial Stewardship Assessment and Promotion Program (ASAP)
- Nebraska Healthcare-Associated Infections (HAI) and Antimicrobial Resistance (AR) Program
- Occupational Safety and Health Administration (OSHA) Law and Regulations
- SHEA

NE ICAP Resources

- Environmental Cleaning & Disinfection
- Hand Hygiene
- Healthcare Laundry
- Infection Control Policies and Infrastructure
- Infection Safety
- Personal Protective Equipment
- Surveillance & Disease Reporting
- Water Exposure

https://icap.nebraskamed.com/all-facility-hub-curated-by-ne-icap/

Long-Term Care Facility Resources

Welcome to your resource page!

Below you will find resources specific to long-term care facilities. For general infection prevention and control links, see ICAP's All Facility Hub.

If you have questions, please reach out to be connected with an ICAP Infection Preventionist. Call (402)552-2881 or email nebraskaicap@nebraskamed.com.

All Facility Hub

Long-Term Care Facility Resources - ICAP

Join Us - Upcoming NE ICAP Webinar

December 11, 2025
- 12:00 – 1:00 PM (CST)
  - SHEA Multi-society guidance for infection prevention and control in nursing homes
    - Dr. Ashraf, a contributing author to the updated guidance, will be presenting.
    - Link: Multisociety guidance for infection prevention and control in nursing homes | Infection Control & Hospital Epidemiology | Cambridge Core

January 8, 2026
- 12:00 – 1:00 PM (CST)
  - Backpacker's Guide to Leadership
    - Dr. Rupp will be presenting at this special event merging LTC, hospital and outpatient audiences. Mark your calendar for this special event and great opportunity to learn about leadership.

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

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.