Guidance and responses were provided based on information known on 12.11.25 and may become out of date.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

December 11, 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.

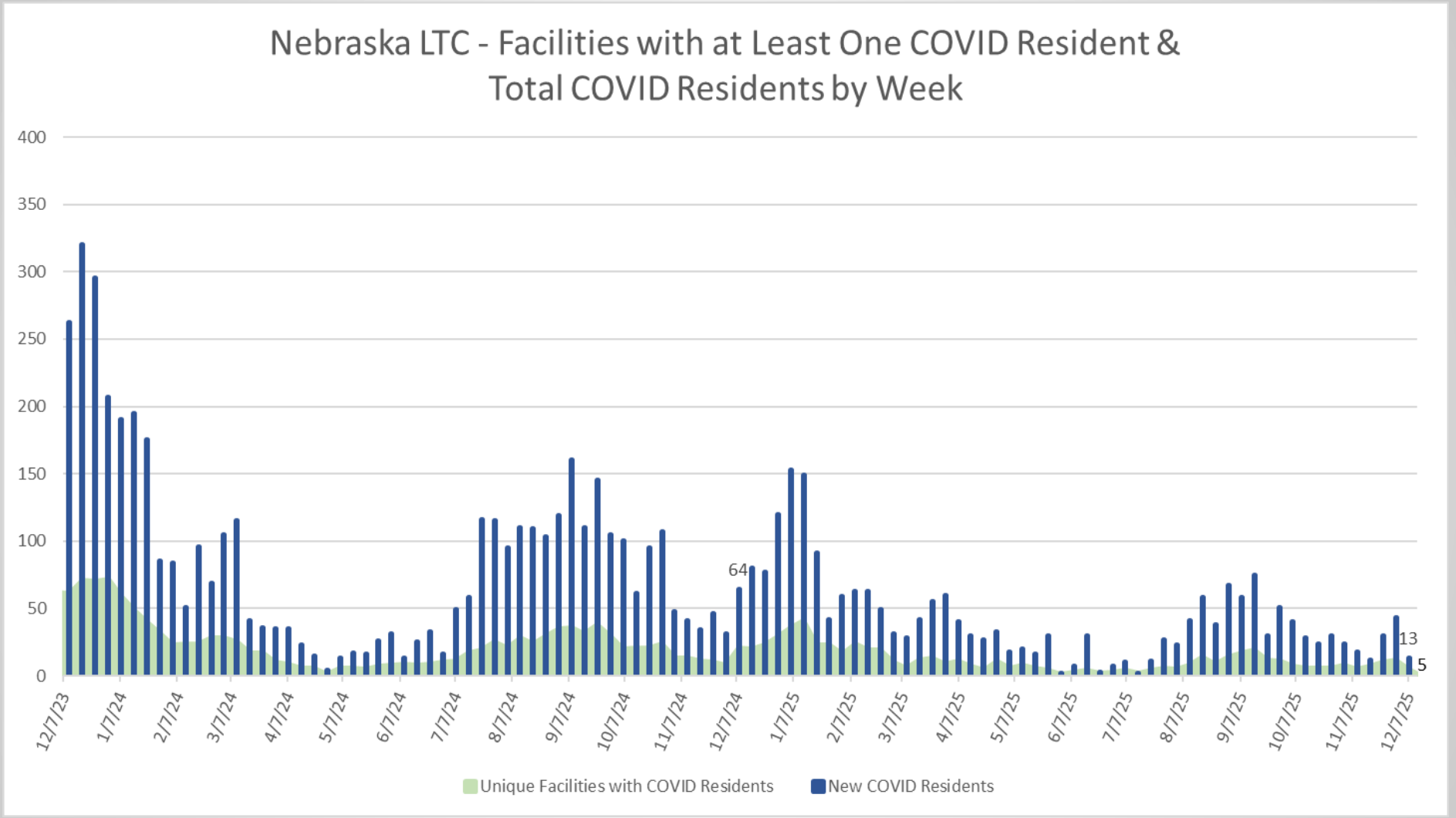
Continuing Education Disclosures

- 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: 12/7/2025
Source: Unofficial Counts Compiled by Nebraska ICAP based on data reported by facilities and DHHS; Actual numbers may vary.

COVID-19 (SARS-CoV-2) Surveillance Data, MMWR Week 48

All data are preliminary and may change as more reports are received. Data through week ending 11/29/2025

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
11/29/2025	96	↑ 1	5.4%	↑ 1.5%
Season Total	**767**		**4.2%**	

COVID-19 HOSPITALIZATION SURVEILLANCE

COVID-19 Hospitalizations and Change from Last Week

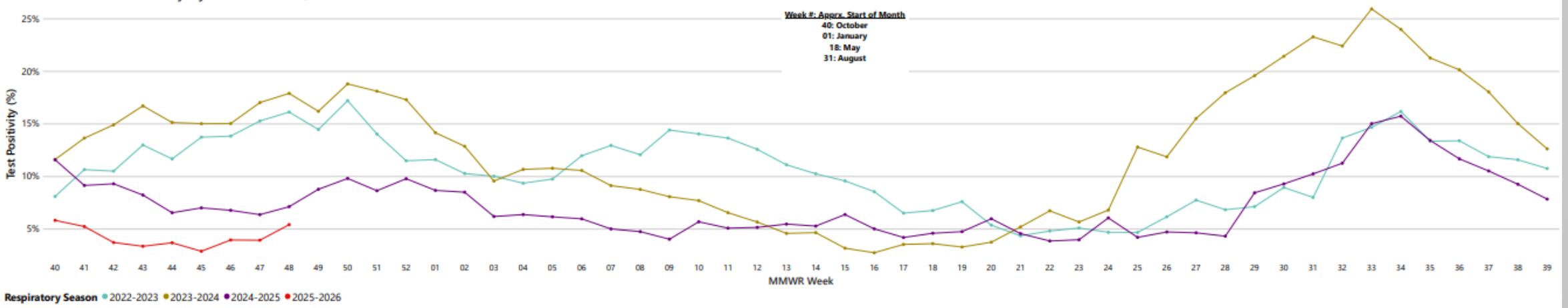
Week Ending Date	Total COVID-19 Hospitalizations	Change from Last Week
11/29/2025	19	↓ 4
Season Total	**160**	

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

MORTALITY SURVEILLANCE: 10 COVID-19 associated deaths have been reported during the 2025-26 surveillance season.

National COVID-19 Summary: Please see https://www.cdc.gov/covid/php/surveillance/index.html. **For information on the prevention of COVID-19**, please see: https://www.cdc.gov/covid/prevention/index.html

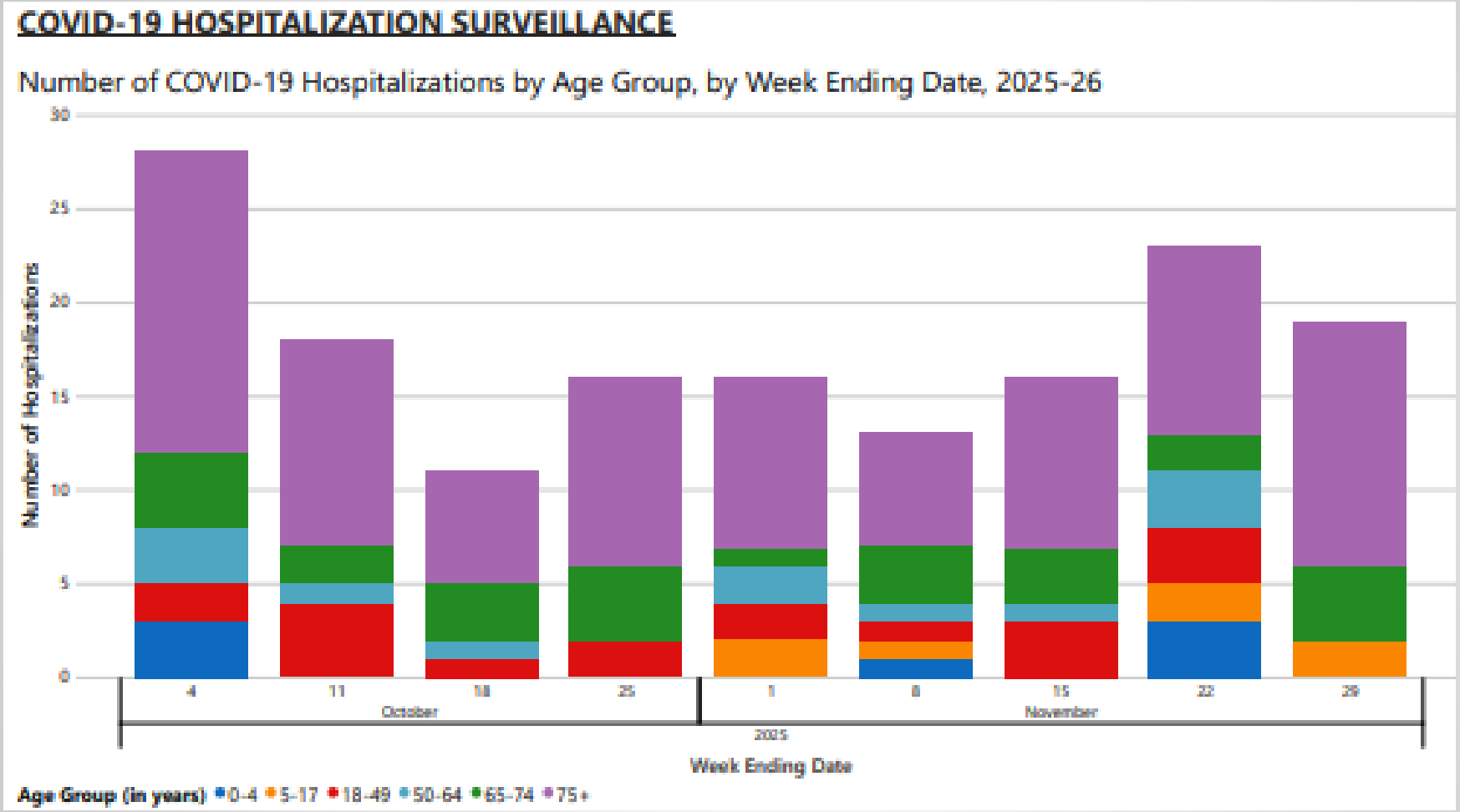
SARS-CoV-2 Test Positivity by MMWR Week, 2022-2026



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

COVID-19 (SARS-CoV-2) Surveillance Data, MMWR Week 48

All data are preliminary and may change as more reports are received. Data through week ending 11/29/2025



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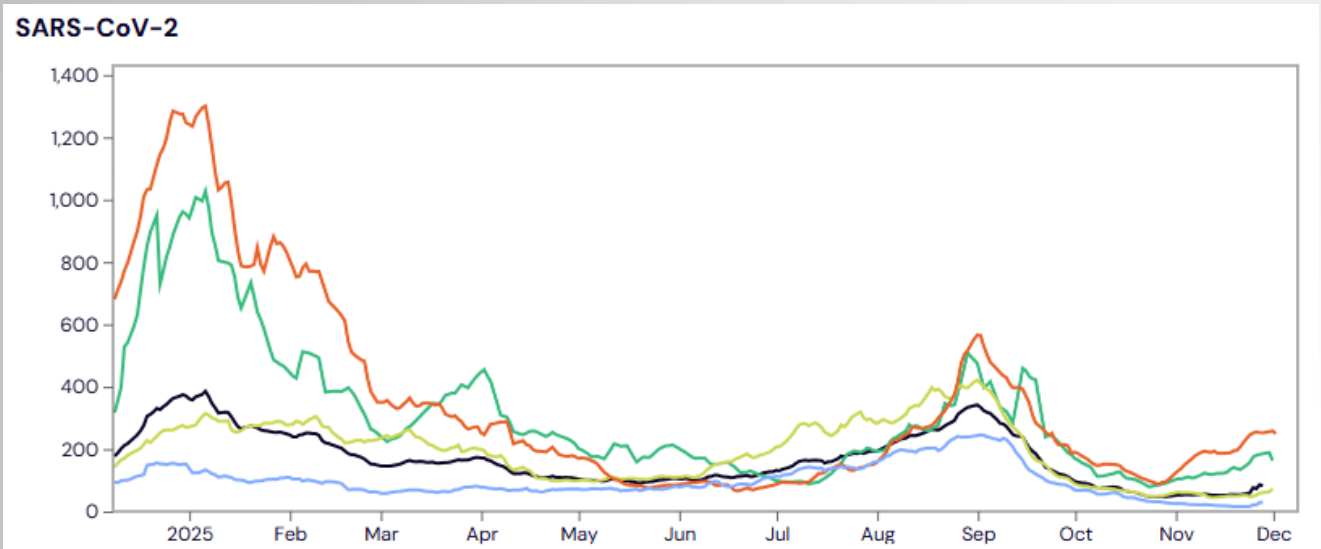
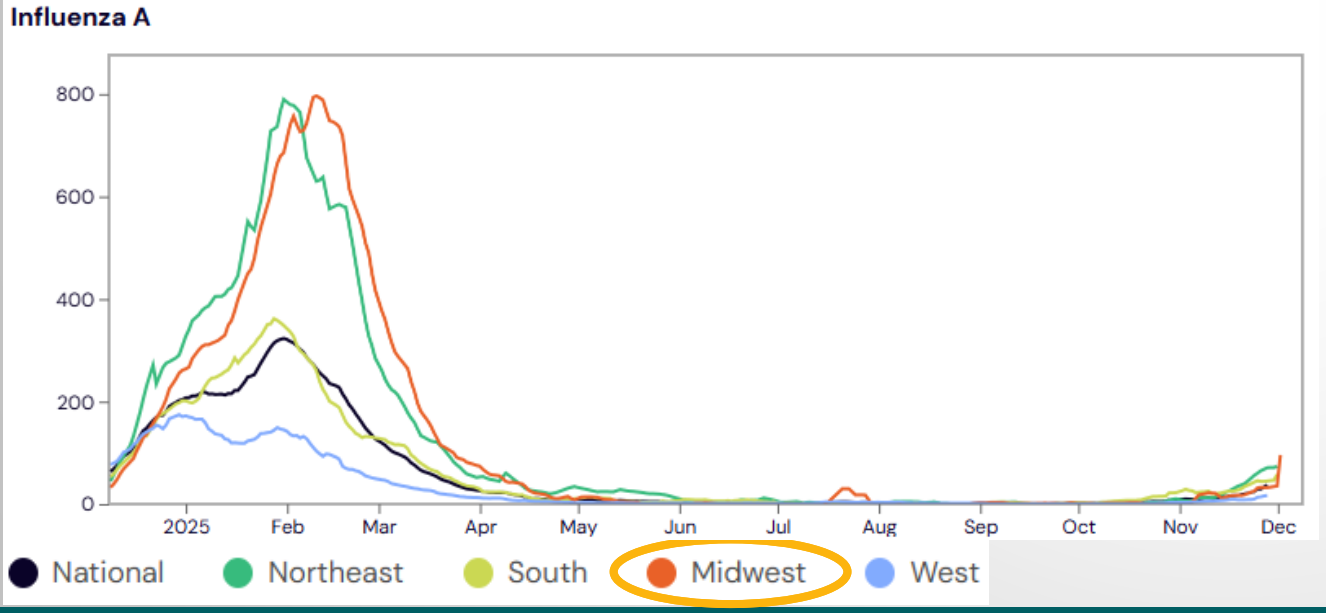
COVID-19 Wastewater Data



SARS-CoV-2

High

Upward trend in the last 21 days and medium concentration



Influenza A

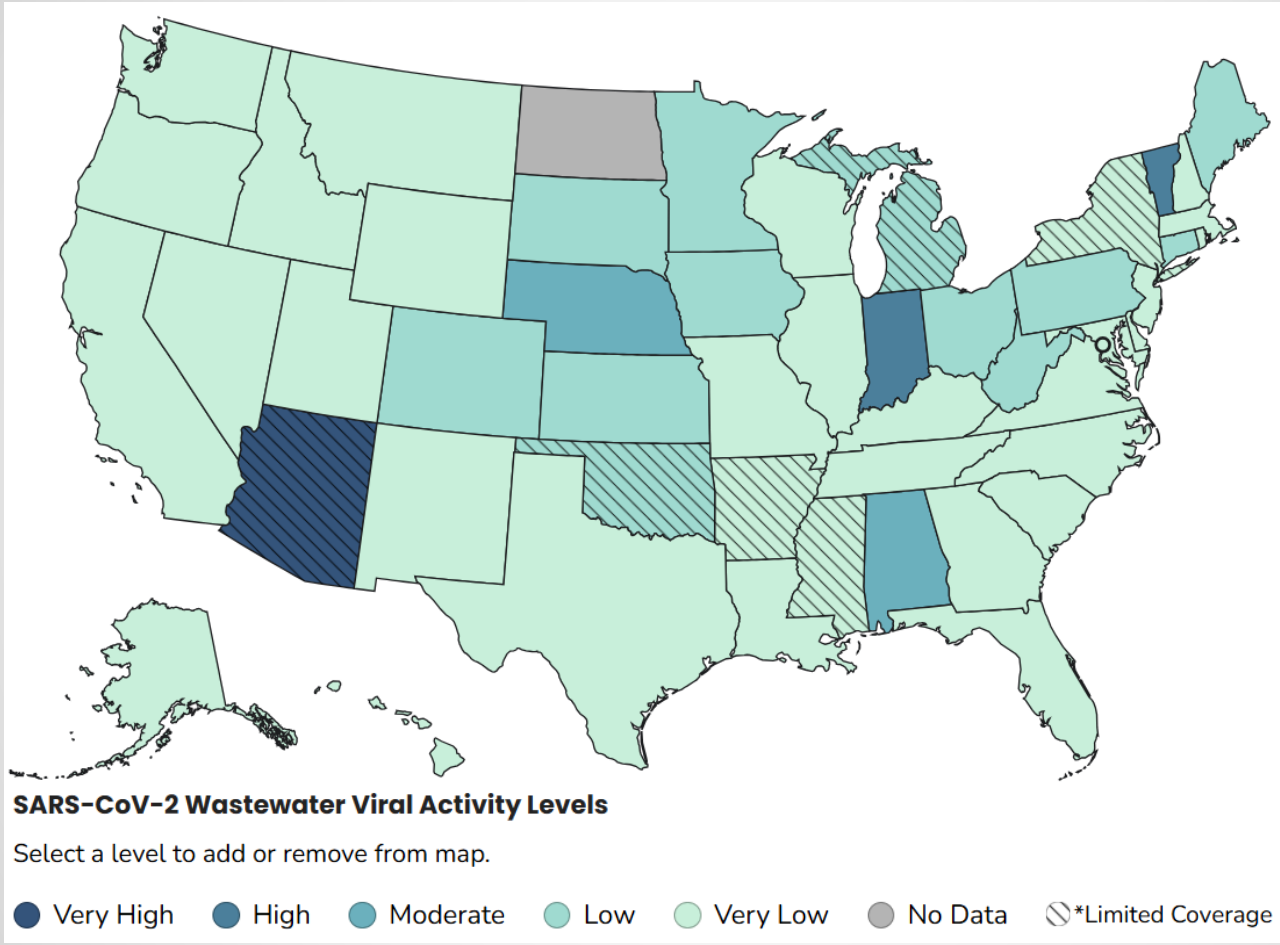
Low

Pathogen is seasonal and not in onset

WASTEWATER SCAN

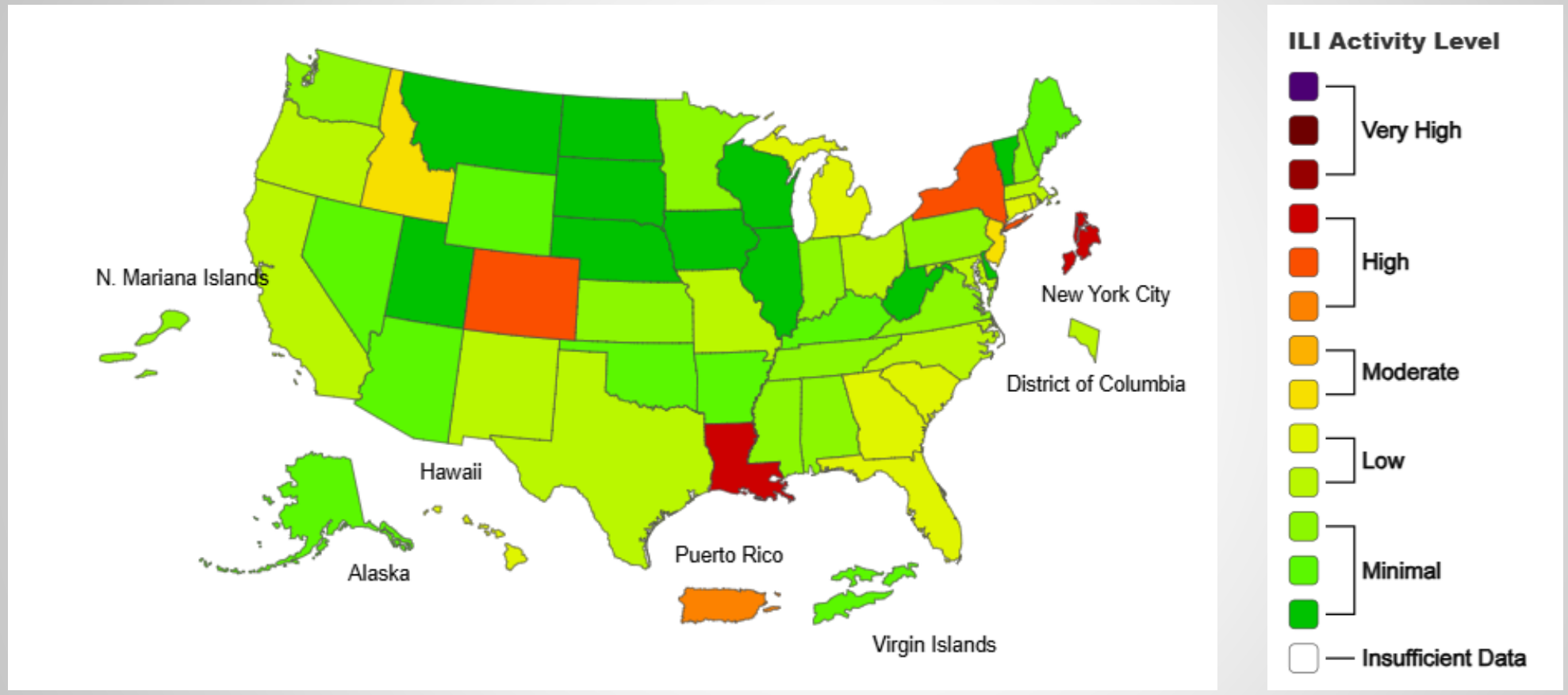
https://www.wastewaterscan.org/en

COVID-19 Wastewater Data



[COVID-19 Wastewater Data – National Trends | NWSS | CDC]

2025-26 Influenza Season Week 48 ending Nov 29, 2025



[Weekly US Map: Influenza Summary Update | FluView | CDC]

Influenza Surveillance Data, MMWR Week 48

All data are preliminary and may change as more reports are received. Data through week ending 11/29/2025

INFLUENZA LABORATORY SURVEILLANCE

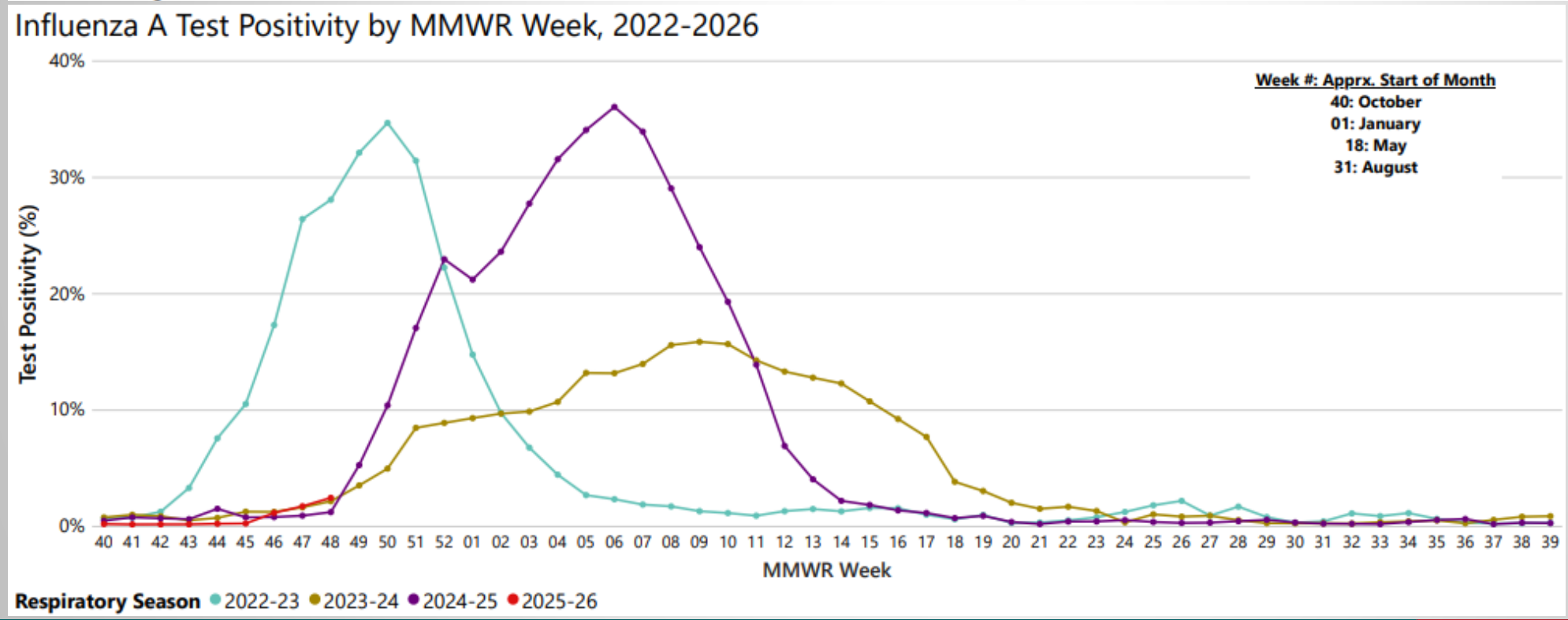
Positive Influenza A & B Tests, Test Positivity, and Changes from Last Week

Week Ending Date	Influenza A Positives	Change from Last Week	Influenza B Positives	Change from Last Week	Influenza Test Positivity	% Change from Last Week
11/29/2025	68	↑ 10	8	↓ 4	2.7%	↑ 0.7%
Season Total	**192**		**62**		**1.0%**	

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: <6 influenza-associated deaths have been reported during the 2025-26 surveillance season.

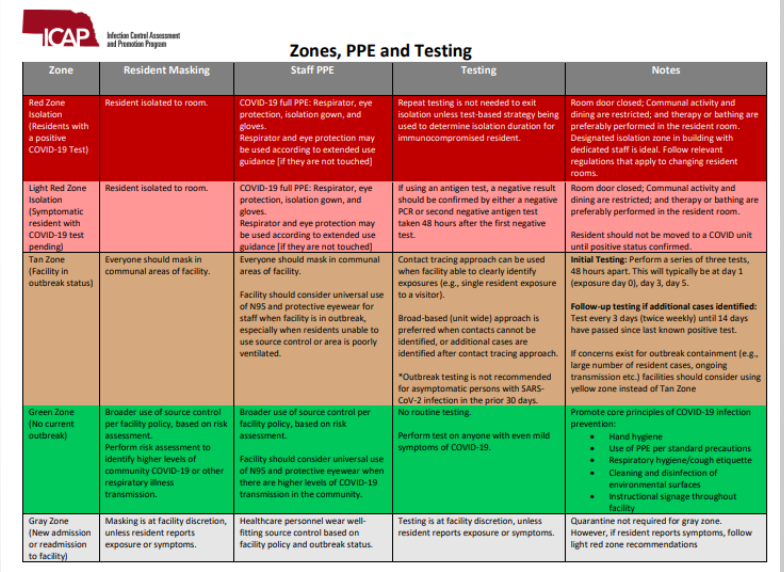


Stay Prepared for Managing Outbreaks

Early identification is key in implementing effective IPC mitigation measures.

Resources and Tools from Nebraska ICAP for the LTC Setting

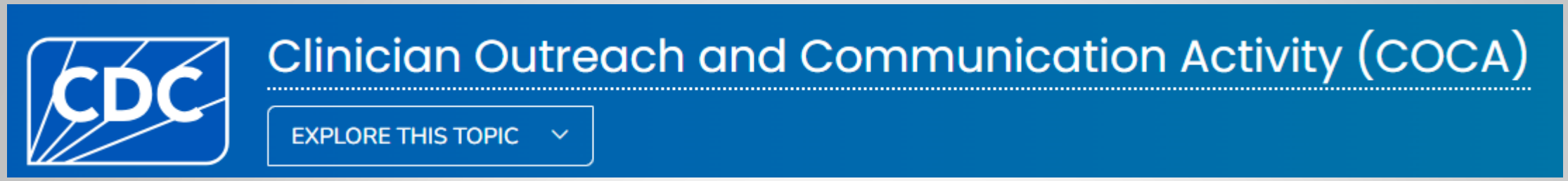
- ICAP Summary of Recommendations for COVID-19 in a Long Term Care Facility
- Zones PPE and Testing



ICAP Infection Control Assessment and Promotion Program

Zones, PPE and Testing

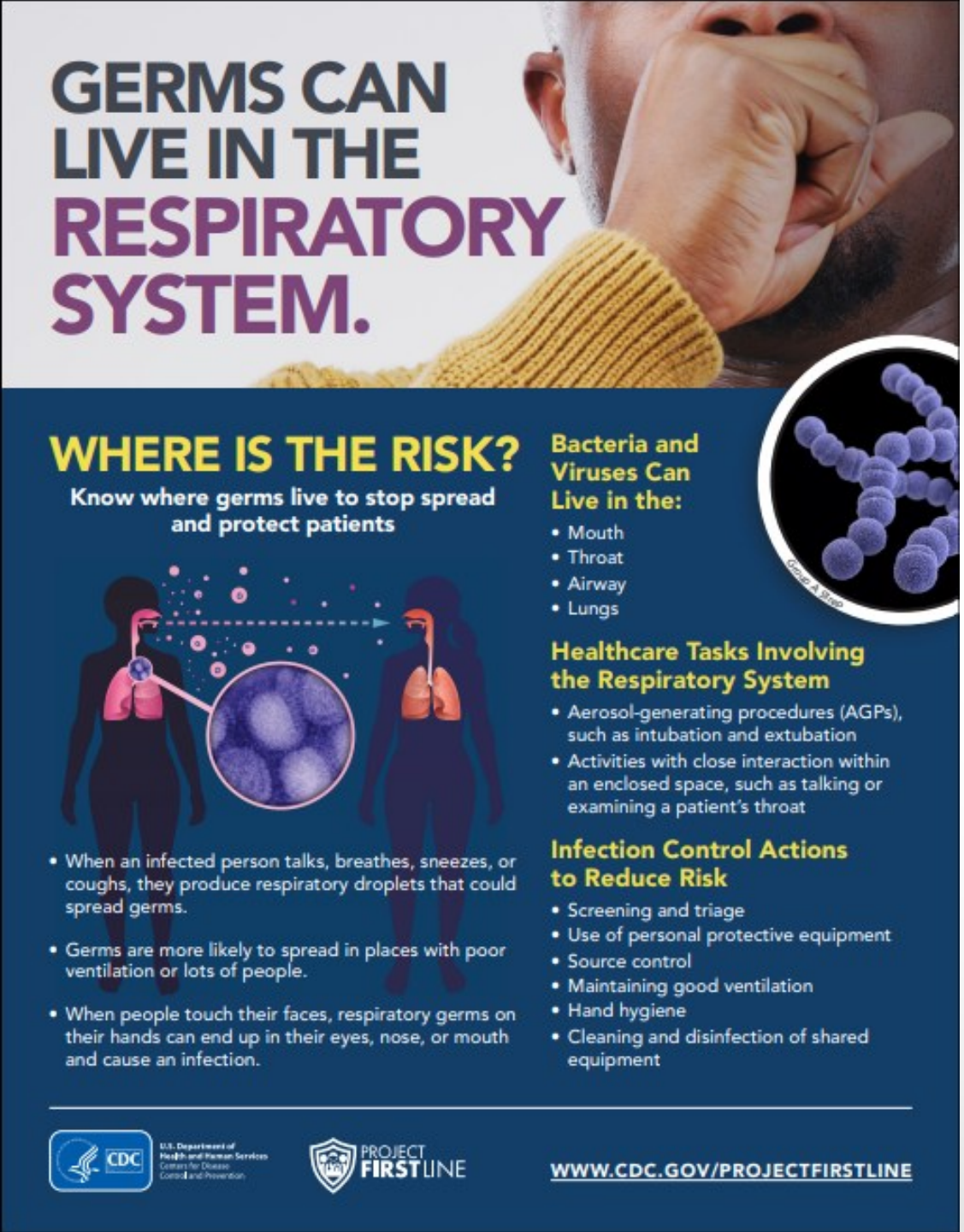
Zone	Resident Masking	Staff PPE	Testing	Notes
Red Zone Isolation (Residents with a positive COVID-19 Test)	Resident isolated to room.	COVID-19 full PPE: Respirator, eye protection, isolation gown, and gloves. Respirator and eye protection may be used according to extended use guidance [if they are not 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. 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. 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. 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). Broad-based (unit wide) approach is preferred when contacts cannot be identified, or additional cases are identified after contact tracing approach. *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. **Follow-up testing if additional cases identified:** Test every 3 days (twice weekly) until 14 days have passed since last known positive test. 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. 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. 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. Perform test on anyone with even mild symptoms of COVID-19.	Promote core principles of COVID-19 infection prevention: • Hand hygiene • Use of PPE per standard precautions • Respiratory hygiene/cough etiquette • Cleaning and disinfection of environmental surfaces • 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



2025 – 2026 Clinical Recommendations for Seasonal Influenza Prevention and Control

Presenters will provide an overview of the burden of influenza disease and discuss recommendations for influenza vaccination, testing, and treatment for people of all ages for the 2025-2026 season.

2025 – 2026 Clinical Recommendations for Seasonal Influenza Prevention and Control | COCA | CDC



CDC Project Firstline Resource

Infection Control Actions to Reduce Risk

- Screening and triage
- Use of personal protective equipment
- Source control
- Maintaining good ventilation
- Hand hygiene
- Cleaning and disinfection of shared equipment

CDC Project Firstline - Respiratory System Infographic

Review of SHEA Multi-society guidance for infection prevention and control in nursing homes

M. Salman Ashraf, MBBS
Medical Director NE DHHS HAI/AR Program

NE ICAP

Review of SHEA Multi-society guidance for infection prevention and control in nursing homes

Multi-society guidance endorsed by SHEA, APIC, IDSA, PALTmed, and AGS.

- An infection prevention and control (IPC) resource for program leaders in nursing homes who are aiming to enhance infection prevention efforts.
    - Gives consideration to the increasing complexity of nursing home care and the challenges of maintaining a home-like care environment.

Multisociety guidance for infection prevention and control in nursing homes | Infection Control & Hospital Epidemiology | Cambridge Core

Review of SHEA Multi-society guidance for infection prevention and control in nursing homes

Most LTC facility policies cite Centers for Disease Control (CDC) as nationally recognized evidence-based infection control guidance. This updated SHEA guidance accounts for the role of regulatory bodies like CMS and CDC and is not intended to replace CDC's guidance nor are there differing recommendations.

The SHEA multi-society guidance includes:

- Additional details to enhance current guidance (e.g., CDC),
- Theoretical rationale, and
- Practical considerations including implementation strategies.

Note: Due to the length and complexity of the SHEA guidance, the contents of the document will not be covered in full in this presentation. This presentation will cover highlights of the guidance that we feel may be used to enhance your facility's current policies and procedures. The full document is available online:
Multisociety guidance for infection prevention and control in nursing homes | Infection Control & Hospital Epidemiology | Cambridge Core

SHEA Multi-society guidance for infection prevention and control in nursing homes: Intended Audience

Primary audience:

IPC program leaders in US nursing homes

Could also be applicable to:

Other residential care settings, such as assisted living communities or intermediate care facilities (however, implementation should be informed by unique considerations of those settings)

IPC Leadership

- There should be at least one dedicated infection preventionist (IP) to manage the IPC program.
- Sufficient and dedicated time for IPC duties should be based on the complexity of the resident population and services provided.
  - At least 1.0 FTE, if the facility has over 100 licensed beds or provides on-site ventilator or hemodialysis services
  - At least 0.5 FTE, if fewer than 100 beds
- The nursing home should provide dedicated time and financial support for the IP to receive specialized training and ongoing education in IPC. Specialized training should also include topics of leadership, managing programs.
- Administrative leadership, including the medical director, should actively participate in IPC program activities and provide clinical insight into protocols and processes.
- Access to information technology training and infrastructure to support facility-level surveillance activities and access to public health surveillance programs.

Maintain Continuity of IPC Program

- Provide **ongoing**, job-specific IPC training due to the likelihood that turnover of HCP leads to decreasing effectiveness of the IPC program
- Identify and mentor individuals who participate in quality improvement initiatives and/or demonstrate interest in IPC; provide incentives for both mentors and mentees
- Encourage and support participation in public health activities and with other organizations that work in IPC (e.g., APIC, SHEA)
- Develop processes for succession planning, transitions, and cross-training for the activities that support the IPC program (e.g., conducting surveillance, developing IPC policies, implementing antimicrobial stewardship)
- Reduce decision fatigue with checklists and standard processes

Learning Center – ICAP/ ASAP Education on Your Own Time

Contract Staff and Services

- Nursing homes should involve the IPC program in identifying IPC risks related to the proposed services (e.g., wound care podiatry) and the IPC program should participate in hiring considerations and defining contractors' responsibilities

- Contract employees and consultants should follow the same IPC training and occupational health vaccination requirements that are applied to HCP who are directly hired by the nursing home.
  - This expectation should be made clear at the time of contract negotiations and included in the contract itself

- If the contracted service provides annual IPC training to the HCP, the nursing home should provide additional orientation and education on facility-specific IPC protocols (e.g., the use of signage in the facility for Transmission-Based Precautions, proper use of facility-approved disinfectants Including contact time)

- Perform periodic audits to ensure compliance with the facility's IPC protocols related to the contracted services and provide appropriate feedback

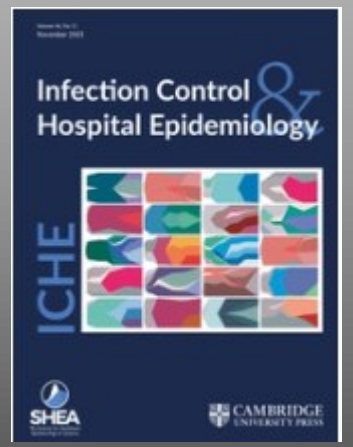
Effective Hand Hygiene

Place ABHS dispensers where they are easily accessible at a room's entry and at the point of care.

- Although concern that cognitively impaired residents may be injured by ingestion of ABHS is cited as a barrier to installation of ABHS dispensers in hallways and rooms, instances of ingestion are exceedingly rare. The benefits of increasing ABHS access to support hand hygiene outweigh potential risks.

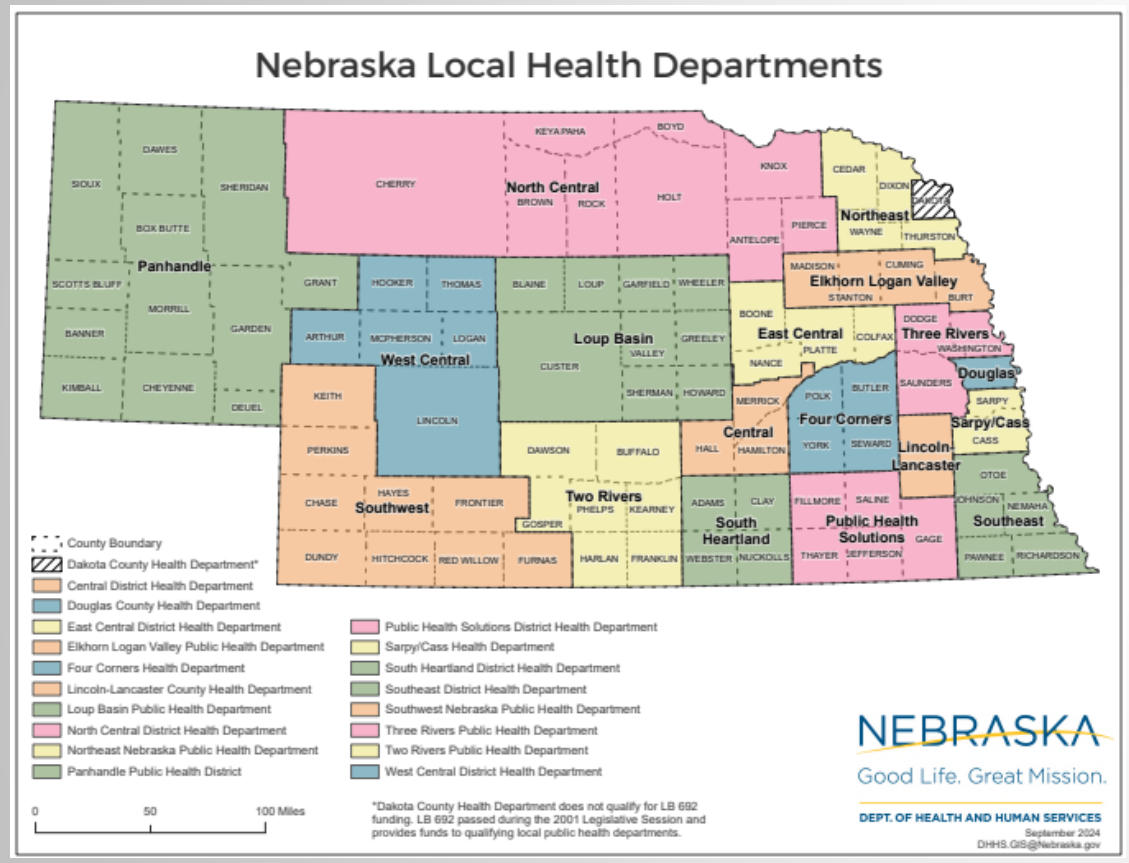
- In secure units, alcohol-based hand sanitizers that remain under the control of the healthcare worker, such as an individual pocket-sized bottle, or specially designed anti-ligature wall-mounted dispensers are strategies that make product available to HCP who care for and interact with residents with cognitive or behavioral impairment.

SHEA/IDSA/APIC Practice Recommendation: Strategies to prevent healthcare-associated infections through hand hygiene: 2022 Update



SHEA/IDSA/APIC Practice Recommendation: Strategies to prevent healthcare-associated infections through hand hygiene: 2022 Update | Infection Control & Hospital Epidemiology | Cambridge Core

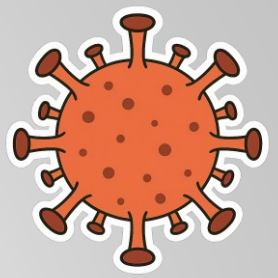
Working with Public Health Department

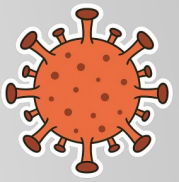


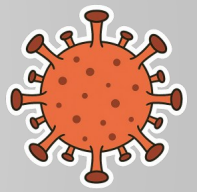
Local Health Departments

- Develop a relationship with local/regional and state public health departments for support, guidance, and collaboration.
- Comply with reporting of cases and outbreaks of infectious diseases as required by local and state public health departments.
- Partner with public health departments, local hospitals, and other healthcare organizations in quality improvement and safety collaboratives to support antimicrobial stewardship, to prevent infections, outbreaks, and the spread of MDROs, and to improve resident outcomes.

Outbreak Preparedness







- Nursing homes should train and educate HCP to notify the IPC program of suspected cases of gastrointestinal, respiratory, and skin and soft tissue infections in residents. Policies and procedures should include:
  - Criteria for initiation of Transmission-Based Precautions (TBP)
  - Communication to visitors to postpone non-urgent in-person visitation if they are ill
  - Guidance to staff about whether they should be excluded from work as a result of an infectious illness
- IP should work with local resources (i.e., public health departments) to diagnose new cases and respond appropriately
- Vaccinate residents and HCP
- Have the capacity to perform point-of-care testing for early detection of viral respiratory pathogens
- Identify approaches for the facility's access to and use of early therapeutics

Application of TBP When Residents Unable to Tolerate IPC Interventions (e.g. Significant Cognitive impairment)

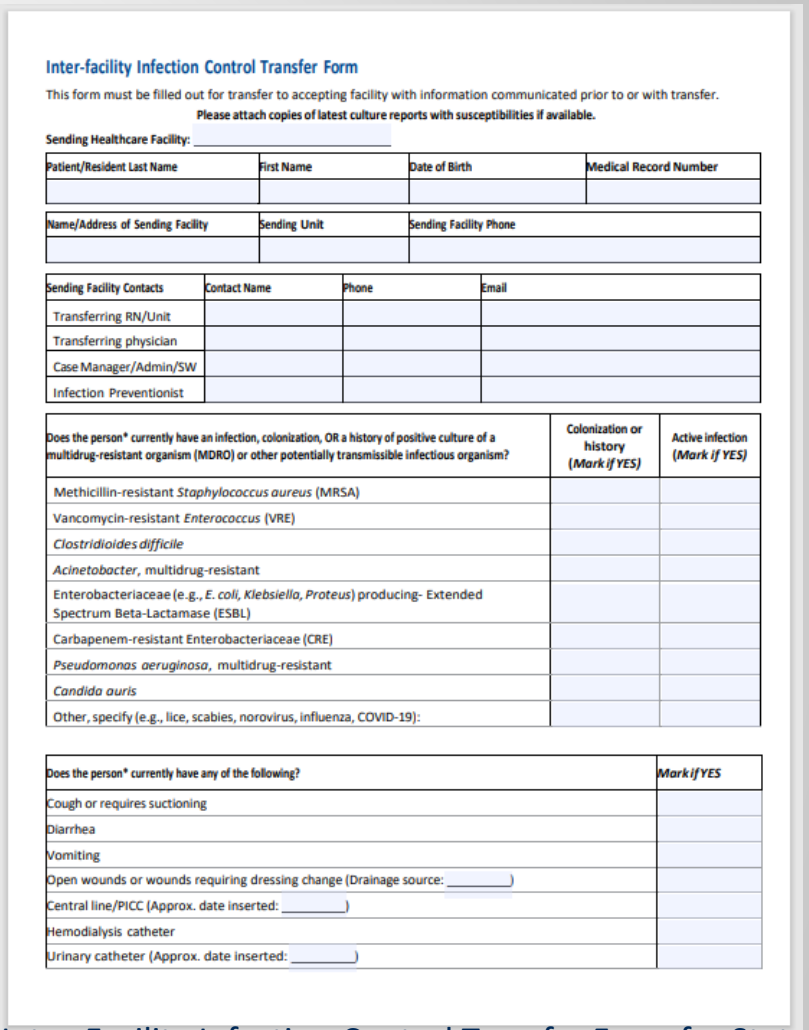
During outbreaks, when feasible, the nursing home should focus on interventions that do not require residents' participation.

- Emphasize prevention measures that do not depend on room restriction to prevent spread among all residents .
  - Vaccination
  - Therapeutics

- During outbreaks, utilize horizontal IPC approaches, which are intended to control the spread of multiple organisms simultaneously
  - Increased frequency of cleaning and disinfection
  - Universal use of masks
  - Hand hygiene, including having HCP routinely assist residents in performing hand hygiene

IPC Communication During Resident Transfer

- History of colonization or infection with MDROs
- Relevant microbiological data, including cultures and susceptibilities
- Pending test results
- The need for and type of Transmission-Based Precautions
- The presence of indwelling medical devices, wounds, diarrhea, or uncontained secretions
- Current skin conditions
- Recent or current antimicrobial exposure
- Vaccination status for relevant vaccines (e.g., influenza, pneumococcus, COVID-19).



Inter-facility Infection Control Transfer Form

This form must be filled out for transfer to accepting facility with information communicated prior to or with transfer.

Please attach copies of latest culture reports with susceptibilities if available.

Sending Healthcare Facility: _____

Patient/Resident Last Name	First Name	Date of Birth	Medical Record Number

Name/Address of Sending Facility	Sending Unit	Sending Facility Phone

Sending Facility Contacts	Contact Name	Phone	Email
Transferring RN/Unit			
Transferring physician			
Case Manager/Admin/SW			
Infection Preventionist			

Does the person* currently have an infection, colonization, OR a history of positive culture of a multidrug-resistant organism (MDRO) or other potentially transmissible infectious organism?	Colonization or history (*Mark if YES*)	Active infection (*Mark if YES*)
Methicillin-resistant *Staphylococcus aureus* (MRSA)		
Vancomycin-resistant *Enterococcus* (VRE)		
Clostridioides difficile		
Acinetobacter, multidrug-resistant		
Enterobacteriaceae (e.g., *E. coli*, *Klebsiella*, *Proteus*) producing- Extended Spectrum Beta-Lactamase (ESBL)		
Carbapenem-resistant Enterobacteriaceae (CRE)		
Pseudomonas aeruginosa, multidrug-resistant		
Candida auris		
Other, specify (e.g., lice, scabies, norovirus, influenza, COVID-19):		

Does the person* currently have any of the following?	*Mark if YES*
Cough or requires suctioning	
Diarrhea	
Vomiting	
Open wounds or wounds requiring dressing change (Drainage source: _____)	
Central line/PICC (Approx. date inserted: _____)	
Hemodialysis catheter	
Urinary catheter (Approx. date inserted: _____)	

Inter-Facility Infection Control Transfer Form for States Establishing HAI Prevention Collaboratives

HCP Knowledge and Skill in Device Management

- HCP should be knowledgeable about medical devices (e.g., central lines, indwelling urinary catheters, percutaneous gastrostomy tubes, tracheostomy tubes) including:
  - The risks associated with their use
  - Recommended IPC practices during placement, maintenance, and removal.
- Nursing homes should document:
  - The presence, indication for, and duration of a medical device
  - Regular assessment of the ongoing need for a device, presence of signs or symptoms of infection or device malfunction, and opportunities for early and prompt removal
  - Adherence to the recommended steps during insertion, maintenance, and removal of the medical device
- Nursing homes may conduct audits using standardized forms or forms tailored to the needs and processes of the nursing home

Training and Auditing

Allow dedicated time for staff to receive regular job-specific IPC education. Demonstrate competency through assessment.

The SHEA guidance clearly distinguishes competency checks from observational audits and promotes staff engagement in process improvement.

- Competency checks should be done in a controlled environment, such as during scheduled training.
  - Competency training is associated with better work satisfaction and lower turnover rates among nursing home staff

- Observational audits are performed while HCP are in the actual work environment.
  - Provide compliance rates and identify process failures, with a goal of process improvement

Monitoring IPC Practices

- Assess availability of supplies at point of use

- Use findings from the annual IPC risk assessment and infection surveillance data to inform which IPC practices to audit. Commonly audited practices include but are not limited to:
  - Hand hygiene
  - Device insertion, maintenance, and removal
  - Cleaning and disinfection of environmental surfaces and reusable medical equipment
  - Use of PPE
  - Vaccination status of residents and HCP

- HCP who perform practice audits should:
  - Receive training
  - Use standardized tools to support consistent monitoring

Occupational Health

- HCP should receive recommended vaccinations or have documented evidence of immunity against vaccine preventable diseases.
  - Address vaccine hesitancy - campaigns with a greater variety of components (e.g., education, better access, role models, legislation or regulation) are the most effective.
- Promote timely reporting by HCP of signs, symptoms (e.g., fever, cough, diarrhea, vomiting, draining skin lesions), or diagnosed illnesses that may represent a risk to residents and other HCP.
- Support HCP with acute infectious illness to adhere to work restrictions to prevent spread of illness to others in the facility.

Guidelines and Guidance Library | Infection Control | CDC

Cleaning and Disinfection

- Cleaning supplies should be readily available and easily accessible.
  - Use EPA-registered disinfectants approved for use against anticipated pathogens of interest (e.g., C. auris, C. diff, etc.).

- Routinely clean and disinfect resident rooms, shared bathrooms, and shared areas at least once a day.
  - Resident personal items (e.g., canes, walkers, phones) should be considered high-touch surfaces and cleaned/disinfected at least once a day.

- Increase the frequency of cleaning and disinfection during outbreaks.

- Audit practices of environmental cleaning should include regular staff education and performance feedback

Involvement of the IP in the Building

- The IP should develop a close working relationship with the facilities management team to ensure building systems are maintained and optimally functioning, specifically:
  - Water management plan
  - HVAC systems – have an awareness s of the general pattern of airflow throughout the building and the location of return registers and systems that exhaust to the outdoors.
  - Engagement during the planning and execution of any construction projects.

Developing a Water Management Program to Reduce Legionella Growth & Spread In Buildings: A Practical Guide to Implementing Industry Standards

Application of Diagnostic and Antibiotic Stewardship

- Focusing on interventions that target phases of the diagnostic process (e.g., specimen collection) can improve antimicrobial use in the long term. Train HCP and conduct annual competency assessments for when and how to collect clinical specimens for diagnostic testing or culture

- Obtain laboratory support: alerting for MDRO cultures, educating HCP about sample collection and transport procedures, and providing periodic reports on specific diagnostic tests (e.g., number of urine cultures ordered, percent positives, organisms identified on cultures).

- Address antibiotic use with residents during advanced planning meetings.

- Implement a process of medication review upon admission or return of a resident to avoid unnecessary treatments.
  - Consider implementing an antimicrobial timeout within 1 to 2 days of the resident's arrival.

- Consider partnerships when the nursing home antimicrobial stewardship team lacks antimicrobial expertise (e.g., local hospital ASP programs, infectious diseases consultants in their community, ASAP). Home - ASAP

- Contract with dispensing pharmacies to develop facility-specific antimicrobial use reports and to assess antimicrobial orders for safety and appropriateness (i.e., drug-drug interactions; avoidance of drug-bug mismatch, length of therapy, potential for intravenous to oral conversion, and/or de-escalation).

Recommendation Summary for SHEA Multi-society guidance for infection prevention and control in nursing homes

M. Salman Ashraf, MBBS
NE DHHS HAI/AR Medical Director

NE ICAP

Leadership

Infection prevention and control program (IPC program)		
Leadership		
1	What resources (physical, human, financial) are needed to meet the goals of the nursing home's IPC program?	The resources for a nursing home's IPC program should include: 1. At least one infection preventionist (IP) to manage the infection prevention and control (IPC) program who: a. Has ongoing, specialized training in IPC that is financially supported by the nursing home b. Demonstrates commitment to ongoing continuing education in IPC to remain current in developments and strategies to optimize the IPC program c. Has clinical and/or public health experience d. Is an effective communicator, educator, leader, mentor, and collaborator e. Receives training in leading and managing programs 2. Sufficient dedicated time for the IP(s) to manage the IPC program based on the complexity of the resident population and services provided: a. At least one full-time equivalent (FTE) IP, if the facility has more than 100 licensed beds or provides onsite ventilator or hemodialysis services b. At least 0.5 FTE IP (20 IP hours per week), if the facility has fewer than 100 beds and does not provide on-site ventilator or hemodialysis services 3. Adequate staffing (e.g., nursing, clinical) and supplies (e.g., personal protective equipment [PPE], alcohol-based hand sanitizer [ABHS], US Environmental Protection Agency (EPA)-registered disinfectants) to allow healthcare personnel (HCP) to follow all recommended IPC practices 4. Dedicated time for personnel to receive regular job-specific IPC education and demonstrate competency through assessment (see 14 and 15) 5. Access to information technology training and infrastructure (e.g., integrated electronic health records, software applications, internet access) to support facility-level surveillance activities and access to public health surveillance programs 6. Access to expert advice, learning collaboratives, and professional associations specific to IPC (see 6 and 42).
2	To whom should the nursing home IP report?	1. The nursing home IP should report to a designated person in administrative and medical leadership who has knowledge relevant to regulatory and resource needs for the IPC program. 2. The IP should be a member of the Quality Assessment and Assurance (QAA) committee to integrate IPC activities within the quality assessment and performance improvement programs. 3. To be successful, IPC programs require visible and tangible support from all levels of nursing home personnel: a. Administrative and medical leadership and the medical director should actively participate in IPC program activities to provide appropriate resources and training to support the implementation of IPC policies and procedures b. Nursing homes should clearly define the IP position and include dedicated time for the IP in IPC training, continuous education, and modes of communication with facility personnel, including leadership c. Nursing homes should evaluate IPC program surveillance reports and practices using the Quality Assurance Performance Improvement (QAPI) process.

Leadership (continued…) and Risk Assessment

3	How can a nursing home support the continuity of its IPC program?	Nursing homes should implement strategies to retain and mentor HCP for IPC program continuity so that the IPC program is not dependent on one individual: 1. Prioritize and invest in personnel retention strategies, including competitive wages and benefits for the IP 2. Provide ongoing, job-specific IPC training due to the likelihood that turnover of HCP leads to decreasing effectiveness of the IPC program (see 14 and 15). 3. Establish a mentoring program to foster interest in IPC : a. Identify individuals who participate in quality improvement initiatives and/or demonstrate interest in IPC in interactions with nursing/clinical supervisors b. Provide incentives for both mentors and mentees 4. Encourage and support participation in public health activities, local Association for Professionals in Infection Control and Epidemiology (APIC) Chapter meetings, and educational offerings from the Society for Healthcare Epidemiology of America (SHEA) and other professional organizations that work in IPC 5. Develop processes for succession planning, transitions, and cross-training for the activities that support the IPC program (e.g., conducting surveillance, developing IPC policies, implementing antimicrobial stewardship) 6. Reduce decision fatigue with checklists and standard processes 7. Celebrate success and foster a team atmosphere.
Risk assessment		
4	How should a nursing home perform an IPC risk assessment?	1. The nursing home should perform a risk assessment annually to determine the resources needed to identify and reduce the risk for infections among residents and HCP. 2. The nursing home should assess IPC risk factors at the following levels: a. Resident-level (person), such as ventilator use or the presence of an indwelling catheter or other medical device b. Process-level (intervention), such as HCP compliance with hand hygiene, vaccination, and PPE use c. Facility-level, such as location, access to services, and physical infrastructure.

Working partners		
Internal working partners		
5	How should the nursing home's IPC program engage with facilities management?	To proactively manage potential IPC concerns, particularly as they relate to water management, airflow, air filtration, air disinfection, and construction, the IPC program should provide expert input and/or consultation to the facility management team, which may include a facility engineer, maintenance director, and/or industrial hygienist.
External working partners		
6	What should nursing homes consider when deciding whether to hire an infectious diseases or IP consultant?	Nursing homes may consider hiring external infectious diseases or IP consultants if the IPC risk assessment (see 4) reveals resident-level risk factors or process-level practice implementation gaps that require additional expertise (see 42).
7	How should the IPC program engage with the hiring and responsibilities of contract services?	Nursing homes should involve the IPC program in: 1. Identifying IPC risks related to the proposed services (e.g., wound care, podiatry) 2. Participating in hiring considerations and defining contractors' responsibilities 3. Educating contractors about IPC policies and protocols 4. Monitoring contracted services' compliance with IPC protocols.
8	How should nursing homes verify IPC training and vaccination status for contract employees and consultants?	Nursing homes should ensure that the contract and on-boarding processes for all contract employees and consultants include provisions requiring appropriate documentation of IPC training and vaccination status.
9	What relationship should nursing homes have with local and state public health departments?	Nursing homes should: 1. Develop a relationship with local/regional and state public health departments for support, guidance, and collaboration with HCP within the local and regional healthcare continuum. 2. Comply with reporting of cases and outbreaks of infectious diseases are required by local and state public health departments and institutional jurisdictions. Public health departments can help facilities in their efforts to prevent and control pathogen transmission.
		3. Partner with public health departments, local hospitals, and other healthcare organizations in quality improvement and safety collaboratives to support antimicrobial stewardship, to prevent infections, outbreaks, and the spread of MDROs, and to improve resident outcomes.
10	What IPC-specific information should be communicated during resident/patient transfers?	Nursing home HCP involved in resident transfers to or from hospitals, emergency departments, and primary care settings should be proficient in communicating and receiving IPC-specific information, including the resident/patient's: 1. History of colonization or infection with antimicrobial-resistant organisms 2. Relevant microbiological data, including cultures and susceptibilities 3. Pending test results 4. The need for and type of Transmission-Based Precautions 5. The presence of indwelling medical devices, wounds, diarrhea, or uncontained secretions 6. Current skin conditions 7. Recent or current antimicrobial exposure 8. Vaccination status for relevant vaccines (e.g., influenza, pneumococcus, COVID-19).

Working Partners

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Occupational Health and HAI Surveillance

Occupational health		
11	How should nursing homes prevent the transmission of infectious illness from HCP to residents and other HCP?	1. Nursing home personnel and individual HCP, including contractors, consultants, and others who enter the nursing home but may not be directly employed by it, are responsible to adhere to federal, state, and local requirements concerning: a. Vaccinations: i. HCP should receive recommended vaccinations or have documented evidence of immunity against vaccine-preventable disease ii. Nursing homes should: a) Enforce vaccination policies in keeping with vaccine recommendations, including exemptions for medical contraindications and those specified by state and federal regulations b) Track vaccination status of HCP (see 16) c) Utilize programs and resources to improve vaccine uptake (see 12) b. Reporting to public health authorities when an illness identified in the nursing home or among HCP has public health implications or is required to be reported (see 9). 2. Nursing homes should implement policies and processes and that: a. Promote timely reporting by HCP to the nursing home of signs, symptoms (e.g., fever, cough, diarrhea, vomiting, draining skin lesions), or diagnosed illnesses that may represent a risk to residents and other HCP b. Support HCP with acute infectious illness to adhere to work restrictions to prevent spread of illness to others in the facility.
12	How can nursing homes increase vaccine coverage among HCP?	Nursing home administration, medical leadership, and the medical director should: 1. Identify and implement multimodal interventions to increase HCP acceptance of CDC-recommended vaccines 2. Consider the use of educational campaigns and strategies such as onsite delivery of vaccines, time off for receiving and recovering from vaccination, and other ways to promote vaccine uptake and to improve vaccine confidence.
Healthcare-associated infection (HAI) surveillance		
13	How should a nursing home IPC program decide which symptoms, syndromes, and microorganisms to include in its surveillance program?	Nursing homes should: 1. Establish priorities for routine surveillance of HAIs in the nursing home based on the needs of the facility, community risks, and regulatory requirements 2. Adopt standardized definitions and methods of reporting for HAI surveillance.

Healthcare personnel (HCP) training, monitoring, auditing, and feedback		
14	What constitutes minimum IPC competency for nursing homes' frontline (resident-facing) HCP?	Nursing homes should: 1. Select training methods and content that addresses the diversity of the workforce and meets the needs of the HCP being trained 2. Provide job-specific, minimum IPC competency-based training, defined as the "minimum knowledge and skill needed to safely perform a task according to facility standards and policies" 3. Ensure dedicated time for HCP to receive regular, job-specific IPC education and to demonstrate competency 4. Document demonstrations of competency following IPC training 5. Evaluate competency before provision of care, specific procedures, introduction of new equipment or protocols, and on an as-needed basis to prepare for and respond to an infectious diseases event 6. Conduct competency assessments through direct observations by trained observers or online skills training that include: a. Initial or core competency training conducted at-hire or during orientation b. Ongoing competency training done annually or when new skills or knowledge are needed c. Specialized competency training related to an area of specialization, such as wound care, central line dressing change, or tracheostomy care.
15	How should nursing homes monitor IPC practices?	Nursing homes should: 1. Monitor HCP adherence to IPC practices as part of implementing IPC policies 2. Assess the availability of supplies at the point of use to support IPC practices 3. Use findings from the annual IPC risk assessment and infection surveillance data to inform which IPC practices to audit. Commonly audited practices include but are not limited to: a. Hand hygiene b. Device insertion, maintenance, and removal c. Cleaning and disinfection of environmental surfaces and reusable medical equipment d. Use of PPE e. Vaccination status of residents and HCP 4. HCP who perform practice audits should: a. Receive training b. Use standardized tools to support consistent monitoring.
16	What models are effective in implementing, auditing, and providing feedback on IPC policies and procedures?	To effectively develop, disseminate, and implement IPC practices (including bundled practices and quality improvement interventions), nursing homes should: 1. Engage administrative and clinical HCP leadership (e.g., nursing and providers). If applicable, nursing homes should also include corporate leadership 2. Obtain input from HCP for strategies to implement IPC practices 3. Ensure HCP who are implementing practices have adequate time to receive education, appropriate training, and competency evaluation (see 14) 4. Involve HCP in ongoing evaluation of practice implementation and opportunities for improvement 5. Audit and provide feedback on HCP adherence to recommended practices 6. Establish metrics to evaluate the impact of practice implementation and quality improvement.

HCP training monitoring, auditing and feedback

ICAP

Commonly Audited Practices

Commonly audited practices		
17	What should a nursing home's hand hygiene program include?	A nursing home's hand hygiene program should include: 1. Interactive, regular education with demonstrations of technique, auditing, feedback, and access to educational materials 2. Active engagement by the nursing home's leadership, clinical HCP, and nonclinical HCP in the practice and promotion of hand hygiene 3. Easy access to ABHS (see 23).
18	How should nursing homes assess HCP knowledge and skill in device insertion, maintenance, and removal?	1. HCP should be knowledgeable about medical devices (e.g., central lines, indwelling urinary catheters, percutaneous gastrostomy tubes, tracheostomy tubes) including: a. The risks associated with their use b. Recommended IPC practices during placement, maintenance, and removal. 2. Nursing homes should document: a. The presence, indication for, and duration of a medical device b. Regular assessment of the ongoing need for a device, presence of signs or symptoms of infection or device malfunction, and opportunities for early and prompt removal c. Adherence to the recommended steps during insertion, maintenance, and removal of the medical device 3. Nursing homes may conduct audits using standardized forms or audit forms tailored to the needs and processes of the nursing home.
19	How should nursing homes conduct environmental cleaning and disinfection?	Nursing homes should: 1. Have clearly written policies on the processes and time involved in cleaning and disinfection of environmental surfaces in shared areas, and residents' rooms, and for reusable medical equipment 2. Ensure that written policies address the frequency of both routine cleaning and disinfection practices, and cleaning and disinfection practices during outbreak situations (see 30) 3. Audit practices for equipment and areas that are cleaned and disinfected, such as frequency and adequacy of cleaning and adherence to contact time (how long a disinfectant remains wet on a surface) 4. Assess availability of appropriate cleaning and disinfection supplies at the point-of-care, ensuring that products are EPA-registered as effective for the purpose for which they are being used (see 31) 5. Use objective methods for evaluation of routine environmental cleaning, which may include direct observation, fluorescent markers, or adenosine triphosphate (ATP) bioluminescence 6. Focus on HCP education and training and provide regular performance feedback.
20	How should nursing homes ensure proper use of PPE?	Nursing homes should: 1. Develop a written policy for Standard and Transmission-Based Precautions that describes the types of PPE, indications for use, and proper steps for donning (putting on) and doffing (removing) the PPE 2. Provide HCP with ready access to PPE, including gowns, gloves, eye protection, surgical masks, and respirators 3. Ensure HCP properly select and use PPE based on the nature of the resident interaction and the potential for exposure to blood, body fluids, or infectious material 4. Monitor adherence to practices and provide feedback (see 22) 5. Make PPE available at the point-of-care when residents are placed on Transmission-Based Precautions.
21	What should nursing homes' vaccination policies include?	Nursing homes should have written, up-to-date policies for vaccination of residents and HCP that include education, training, and monitoring of vaccination acceptance rates.
22	What methods should nursing homes use to provide feedback on HCP adherence to IPC practices?	1. Nursing homes should use audit and feedback methods to improve and sustain compliance with evidence-based practices: a. For individual HCP, nursing homes should use specific, just-in-time feedback on the process being audited b. At the unit or facility-level, nursing homes should use simplified, aggregated data from audits during rounds, QAA meetings, personnel newsletters, and reporting huddles. 2. Nursing homes should train HCP who conduct these audits to use standardized tools and definitions. 3. Nursing homes should provide feedback to HCP on signs of potential lapses in IPC practices during care.

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Environment of Care

Environment of care		
23	Where should nursing homes place alcohol-based hand sanitizer (ABHS) dispensers?	Nursing homes should: 1. Place ABHS dispensers where they are easily accessible at a room's entry and at the point of care 2. Install ABHS dispensers in accordance with local fire regulations 3. Have a hand hygiene program that includes: a. Widespread availability of hand hygiene products throughout the facility for use by HCP, visitors, and residents b. Engagement of HCP in selection and feedback on products
24	How should nursing homes handle laundry and linens for IPC?	Nursing homes should: 1. Use industrial laundry (onsite or offsite) to process laundry and linens. Exceptions may be made for clothing that is laundered by the resident; however, laundry machines used onsite for clothing that is laundered by the resident or family should be disinfected and maintained in accordance with the laundry machines' MIFUs 2. Store clean laundry and linens in a location that protects them from environmental contamination 3. Educate HCP on safe practices, including PPE selection, when handling and/or changing used linens (e.g., gowns and gloves when handling linens that are grossly soiled) 4. Require HCP to wear gowns and gloves when changing bed linens of residents who are on Enhanced Barrier or Contact Precautions to prevent contamination of clothing and subsequent transmission to other residents.

Outbreak Preparedness and Response

Outbreak preparedness and response		
25	What strategies should nursing homes use to detect and respond to outbreaks?	Nursing homes should: 1. Be aware of viruses and other pathogens circulating in the community 2. Understand how pathogens that typically cause outbreaks enter and spread within a facility and how to implement pathogen-specific symptom screening 3. Educate HCP to identify and report symptoms (residents' symptoms or their own) that may be consistent with transmissible pathogens 4. Implement sick leave policies that promote timely reporting of illness and appropriate action (see 11) 5. Implement early (point-of-care) diagnostic testing to identify pathogens 6. Implement appropriate Transmission-Based Precautions based on symptoms, while awaiting a resident's diagnosis 7. Communicate with referral hospitals and public health departments 8. Vaccinate residents and HCP (see 8 and 11) 9. Identify approaches for the facility's access to and use of early therapeutics.
26	How should nursing homes use point-of-care testing to detect and control the spread of respiratory pathogens?	Nursing homes should: 1. Have the capacity to perform point-of-care testing for early detection of viral respiratory pathogens to prevent them from being introduced into the nursing home when community transmission is present and to enable early treatment of residents 2. Liaise with laboratory or infectious diseases consultants regarding selection of point-of-care tests.
27	How should nursing homes implement respiratory hygiene, cough etiquette, and source control to control the spread of respiratory pathogens?	Nursing homes should have policies and protocols for respiratory hygiene, cough etiquette, and masking for source control to prevent transmission of infection to HCP, visitors, and residents that include: 1. Education of HCP, residents, and visitors in how to prevent transmission of respiratory pathogens 2. Signage and reminders at entrances and in shared areas on hand hygiene and how and when to wear a mask for source control 3. Appropriate and easily accessed supplies (e.g., masks, ABHS) so practices can be followed.
28	How should nursing homes use ventilation to control the spread of respiratory pathogens?	Nursing homes should: 1. Ensure they are compliant with building code requirements for heating, ventilation, and air conditioning 2. Monitor ventilation systems in accordance with engineers' and manufacturers' recommendations to ensure optimal performance
		3. Ensure the IPC program collaborates with facility management, particularly in circumstances when considering implementation of any supplemental strategies to enhance ventilation (e.g., during a facility respiratory pathogen outbreak) (see 5) 4. Have a process in place for isolating residents with pathogens for which an airborne infection isolation room (AIIR) is recommended (e.g., tuberculosis) a. If an AIIR is not available, the residents should be transferred as soon as is feasible to a facility where an AIIR is available. Place a mask on the resident (if tolerated) and isolate the resident in a private room with the door closed, while awaiting transfer.

Strategies for Specific IPC Practices in Nursing Homes

Strategies for specific IPC practices in nursing homes		
Environmental cleaning and disinfection		
30	How frequently should nursing homes clean and disinfect surfaces in residents' rooms, shared bathrooms, and shared common areas?	Although the optimal frequency of cleaning and disinfection of areas in nursing homes remains unclear, nursing homes should provide adequate time for HCP to: 1. Routinely clean and disinfect resident rooms, shared bathrooms, and shared common areas at least once a day, paying particular attention to high-touch surfaces with an EPA-registered disinfectant active against the pathogens most likely to contaminate the resident care environment 2. Perform cleaning immediately upon noticing visibly soiled surfaces 3. Increase the frequency of cleaning and disinfection during outbreaks.
31	What are the cleaning and disinfection considerations for equipment shared among residents (e.g., shower chairs, blood pressure cuffs, mechanical lifts) and residents' personal belongings?	Nursing homes should: 1. At least daily, clean and disinfect residents' frequently used items (e.g., canes, walkers, remotes, tablets, phones) 2. After each use, clean and disinfect items that are shared among residents 3. Choose cleaning products that are EPA-registered for the specific cleaning and disinfection purpose 4. Follow the MIFU for equipment and the cleaning products used to avoid damaging existing equipment and objects. The laundry section (see 24) addresses cleaning of residents' soft items, as appropriate. Care of residents' personal hygiene items (e.g., toothbrushes) are outside the scope of this document.

Resident Placement and PPE Use

Resident placement and PPE use		
32	How should nursing homes use Transmission-Based Precautions for residents who are chronically colonized with MDROs apply to dining (in-room and group), rehabilitation and therapy (in-room and group), recreational, and other high-contact activities, as well as interactions with residents' visitors, including students, trainees, and volunteers?	Nursing homes should: 1. Not restrict residents who are chronically colonized with MDROs from visitation, social activities, dining, rehabilitation and therapy, or recreational activities 2. Apply Enhanced Barrier Precautions for residents infected or colonized with MDROs targeted by CDC. Nursing homes may consider, based on its policies, applying Enhanced Barrier Precautions more broadly to include other epidemiologically important MDROs 3. Not require that visitor(s) seeing a single resident who is chronically colonized with an MDRO wear specific PPE, although nursing homes may offer PPE for high-contact care or for care, in which Standard Precautions would require PPE.
33	How should Transmission-Based Precautions apply to residents unable to tolerate IPC interventions (such as room restriction)	For residents who are unable to tolerate IPC interventions implemented as part of outbreak response, nursing homes should: 1. Emphasize prevention measures that do not depend on room restriction (e.g., vaccination, therapeutics) to prevent spread among all residents 2. Have HCP routinely assist residents in performing hand hygiene
	implemented as part of outbreak response (e.g., individuals with significant cognitive impairment)?	3. During outbreaks, utilize horizontal IPC approaches, which are intended to control the spread of multiple organisms simultaneously.
34	How should nursing homes educate residents, families, and visitors on appropriate IPC practices?	Nursing homes should: 1. Educate and engage residents, families, and visitors in adoption of appropriate practices for hand hygiene, respiratory hygiene, PPE, antibiotic use, vaccination, and practices for the prevention and control of emerging infections and outbreaks 2. Post IPC policies and reminders in nursing home reception areas to reinforce interactions with HCP. Nursing homes may consider including signage at the entrance to the building, at reception, in family newsletters, on digital information screens, and on resident-used tablets and computers.
35	How should nursing homes assess whether to adopt evolving IPC practices to complement current IPC efforts?	No recommendation.

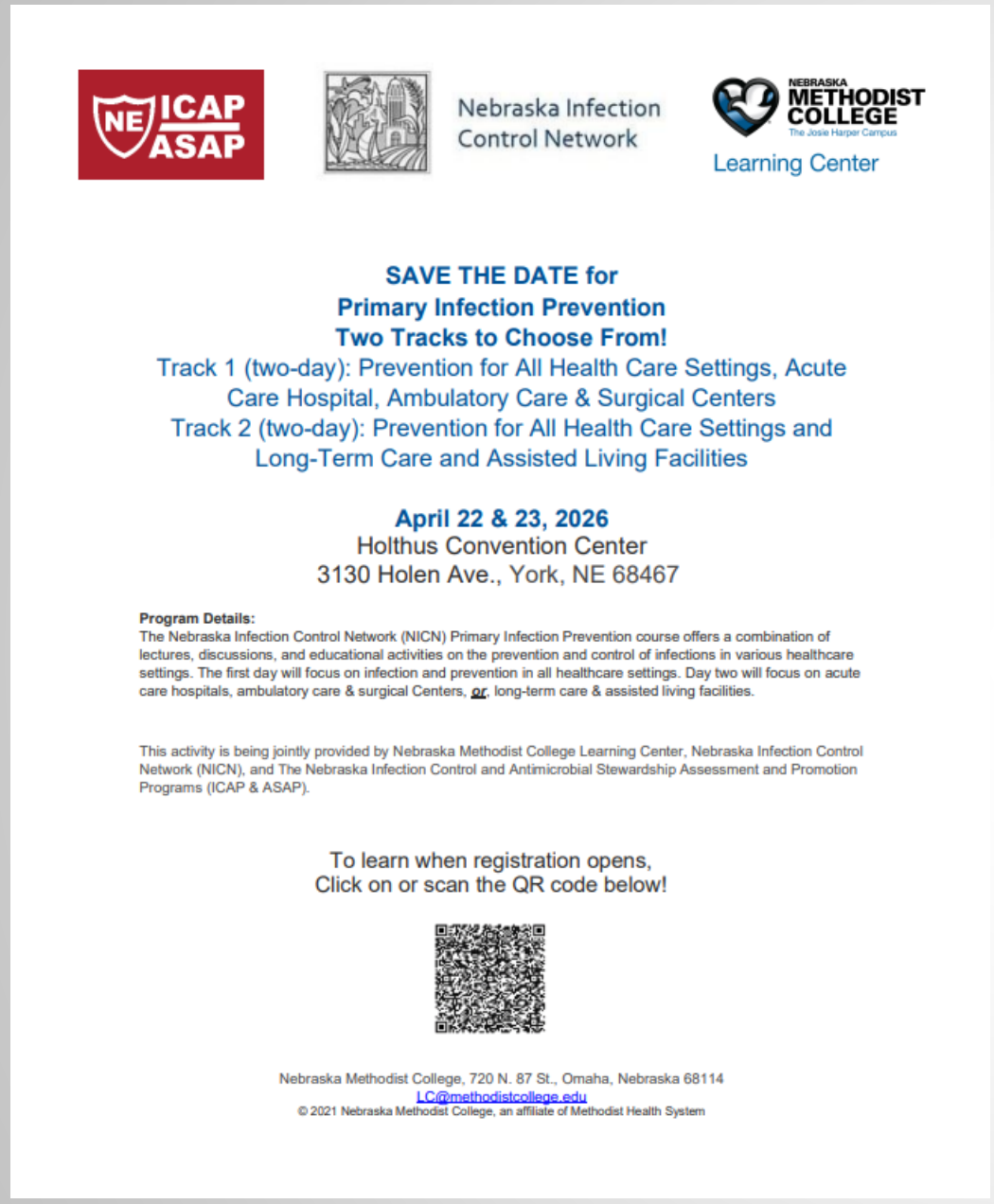
Diagnostic Stewardship/Antimicrobial Stewardship

	Diagnostic stewardship	
36	What is the role of the laboratory in supporting diagnostic stewardship in nursing homes?	In partnering with microbiology laboratories, nursing homes should incorporate the principles of diagnostic stewardship rules in the ordering, interpreting, and reporting.
37	How should HCP be trained in collecting specimens for microbiological culture?	Nursing homes should train HCP and conduct annual competency assessments for when and how to collect clinical specimens for diagnostic testing or culture (e.g., signs and symptoms that may indicate the need for urine collection, nasopharyngeal swab, throat swab; sputum collection, swab sample of frank pus from wound, tracheostomy aspirate, blood culture).
	Antimicrobial stewardship	
38	Who should be involved in supporting a nursing home's antimicrobial stewardship program (ASP)?	The nursing home's ASP should be supported by, at a minimum, the IP, administrative and medical leadership and the medical director, the consulting pharmacist, and leadership from nursing (see 1-3).
39	What strategies are effective for improving antibiotic use in nursing homes?	Nursing home ASPs should: 1. Have antimicrobial use protocols and systems for monitoring antimicrobial use. 2. Provide regular feedback to prescribing clinicians on prescribing of antimicrobials. 3. Combine feedback with education to reduce inappropriate antimicrobial use in nursing homes 4. Consider using peer comparison audit and feedback to make clinicians aware of their prescribing habits.
40	What are effective strategies for implementing ASP policies and metrics of success?	Nursing homes should provide all clinical HCP, including physicians, nurse practitioners, nurses, nurse aides, and allied health professionals with multidisciplinary education about antimicrobial stewardship principles and antimicrobial use protocols.
41	What are the protocols for identifying, assessing, and potentially deprescribing antibiotics for newly transferred residents?	In collaboration with referral hospitals, nursing homes should implement a process of medication review upon admission or return of a resident to avoid unnecessary treatments. The process should include identifying antimicrobial prescription, assessing its appropriateness, and discontinuing the prescription if deemed unnecessary.
42	What is the role of external consultants in a nursing home's ASP?	External partners and/or consultants may serve as antimicrobial stewardship experts for nursing home ASPs, especially when the nursing home antimicrobial stewardship team lacks such expertise. These individuals may contribute toward development of antimicrobial use protocols, processes for tracking antimicrobial use, data analyses and interpretation, providing specific feedback for further improvement, and/or educating HCP, residents, and families.

Questions?

In Closing

NE ICAP



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