Hospital & Outpatient Settings Webinar Series

February 11, 2026

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

NE ICAP

NEBRASKA INFECTION CONTROL ASSESSMENT AND PROMOTION PROGRAM

Presenters & Panelists

Presenters today: *(in order)*

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Continuing Education Disclosures

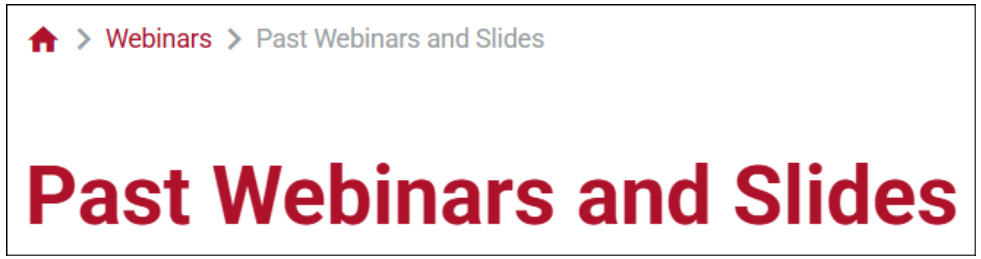
- 1.0 Nursing Contact Hour is awarded for the LIVE viewing of this webinar.
- Nebraska Infection Control Assessment and Promotion Program is approved as a provider of nursing continuing professional development by the VTL Center for Professional Development, an accredited approver by the American Nurses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

Questions & Answer Session

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

Slides & Webinar Recordings Available

- **During** this webinar, slides are available on the NE ICAP Hospital webpage
  - **After** the webinar, slides and a recording will be posted under the Webinars tab on the Past Webinars and Slides webpage



Nebraska Pathogen Watch

Juan Teran, MD
Medical Director, NE ICAP

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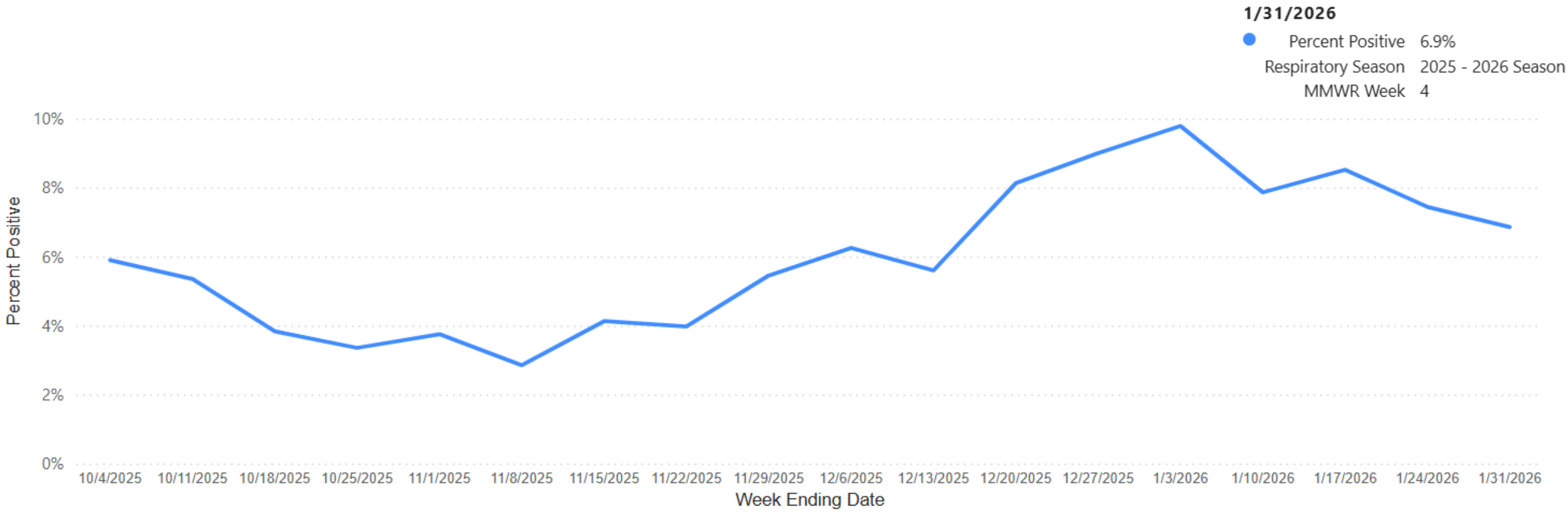
NEBRASKA INFECTION CONTROL ASSESSMENT AND PROMOTION PROGRAM

Key Points

- COVID-19 activity continues to decline
- Flu A activity is gradually decreasing, while Flu B is increasing
- RSV activity is on the rise

COVID-19 NE DHHS Report



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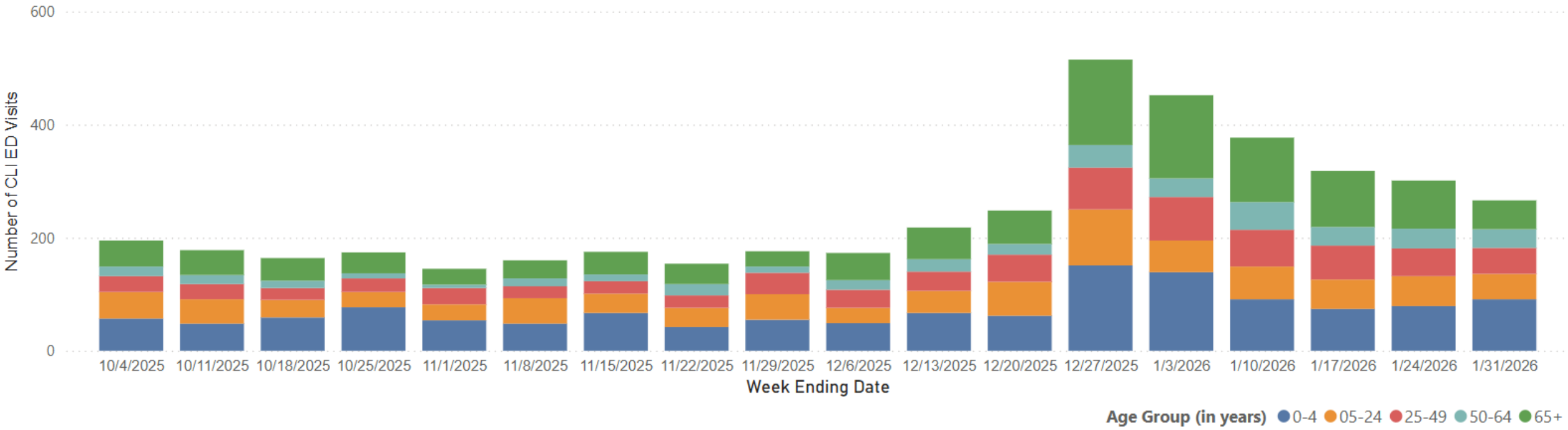
COVID-19 NE DHHS Report



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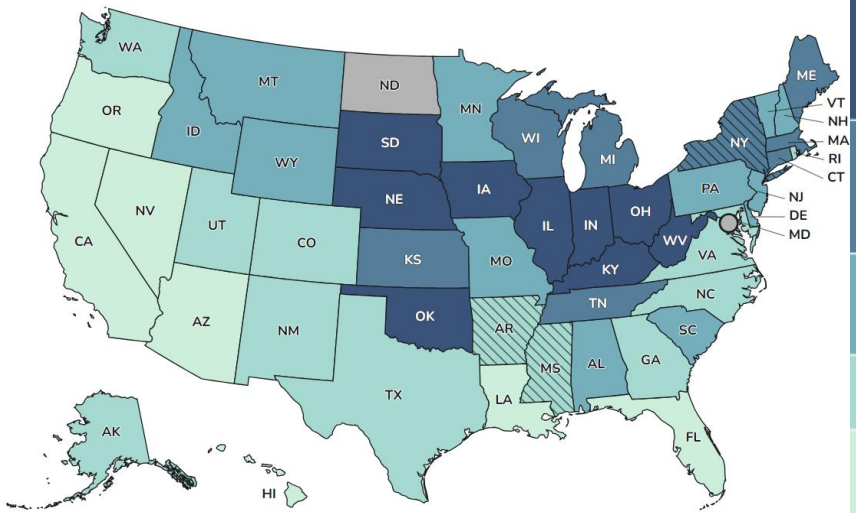
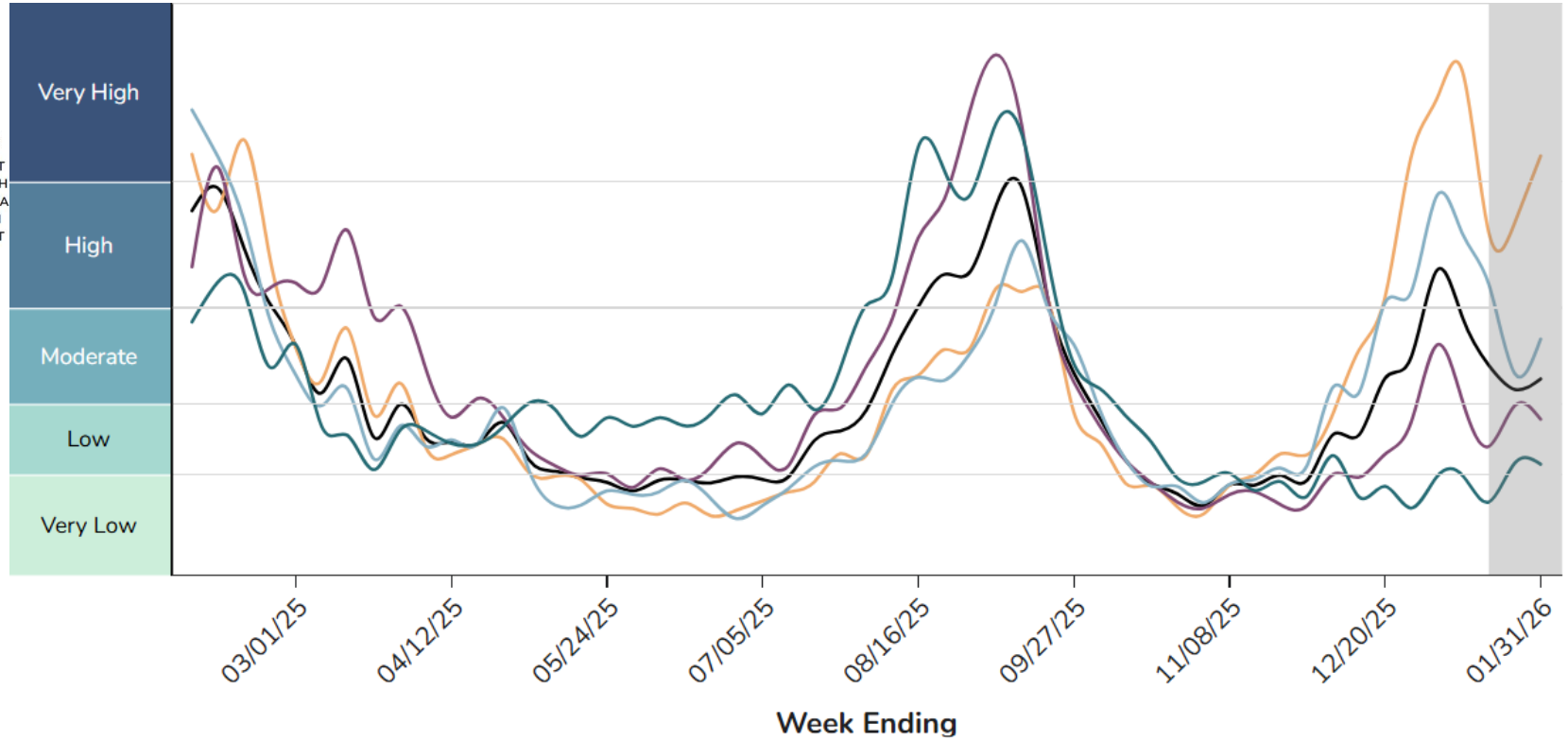
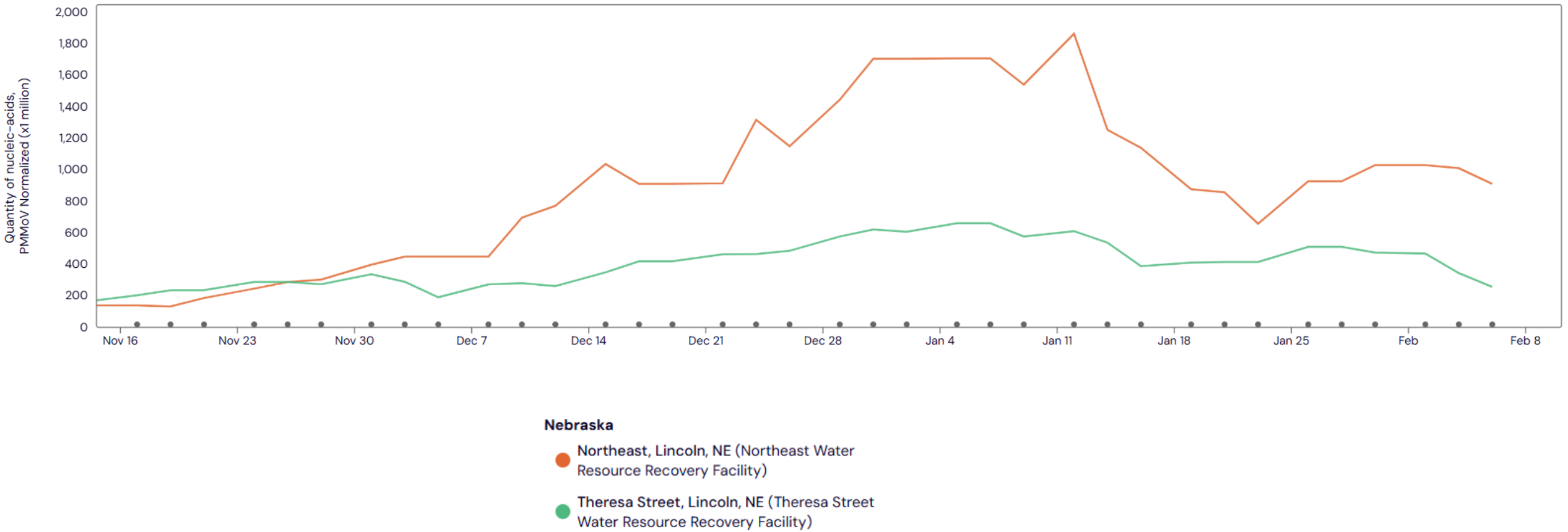
COVID-19 Wastewater Activity





National Midwest South Northeast West

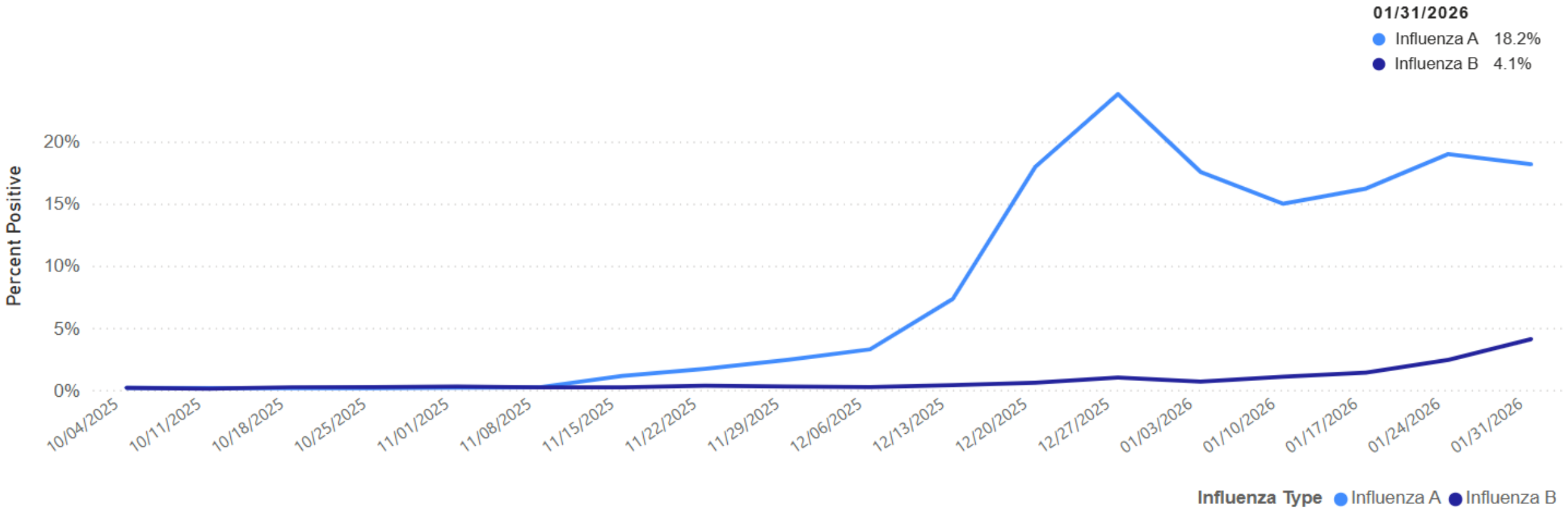
COVID-19 Wastewater Data



WASTEWATER SCAN

NE ICAP

Influenza Percent Positive



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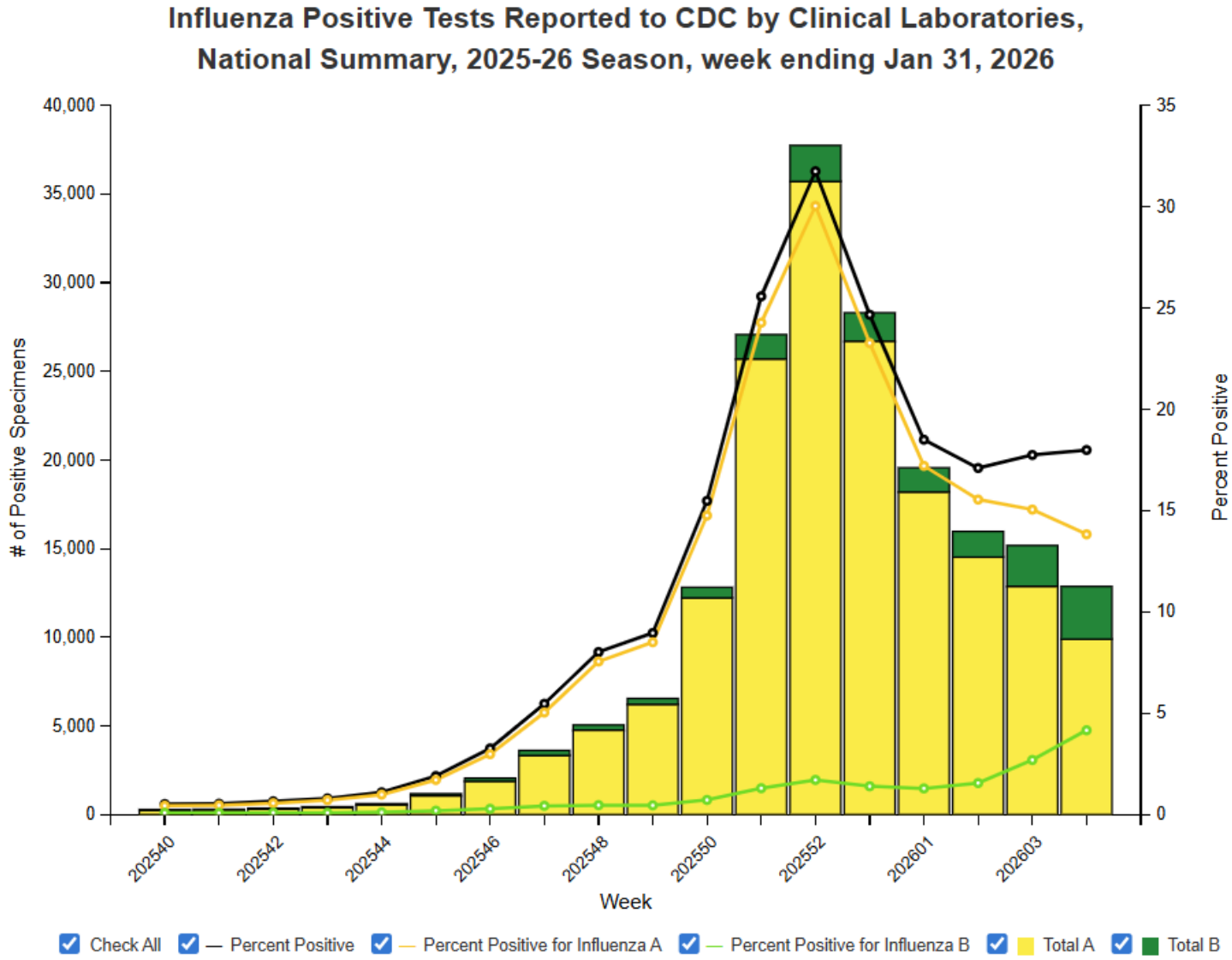
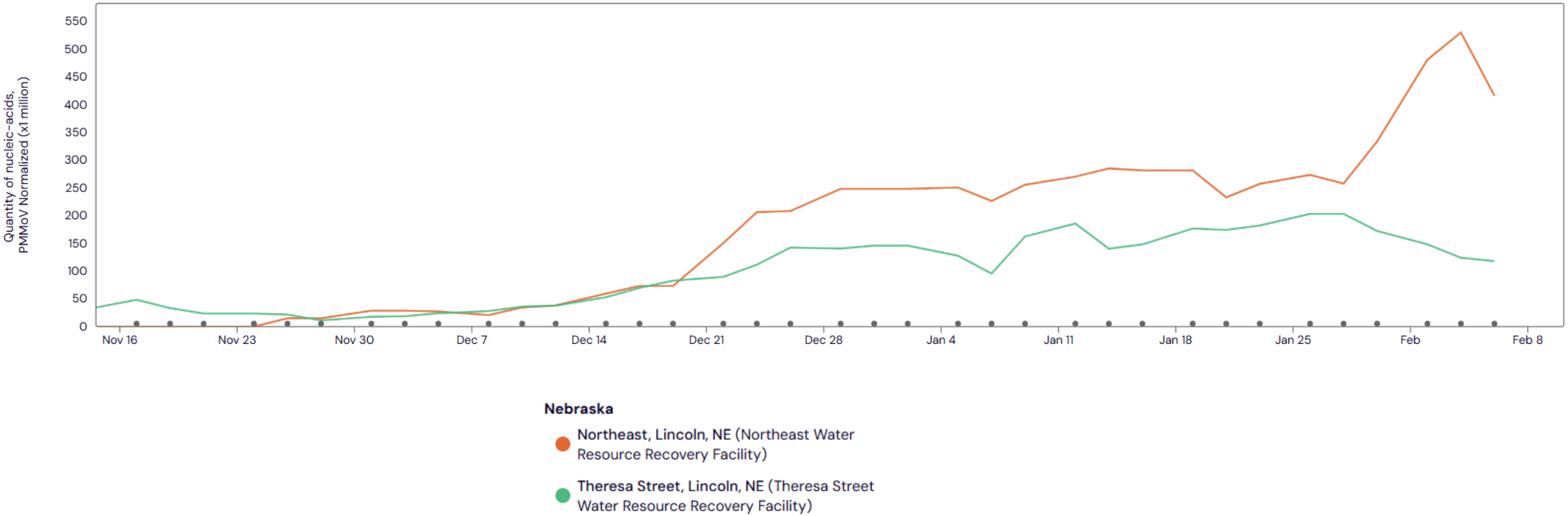
Influenza Cases and Percent Positive



CDC FluView

NE ICAP

Influenza Wastewater Data

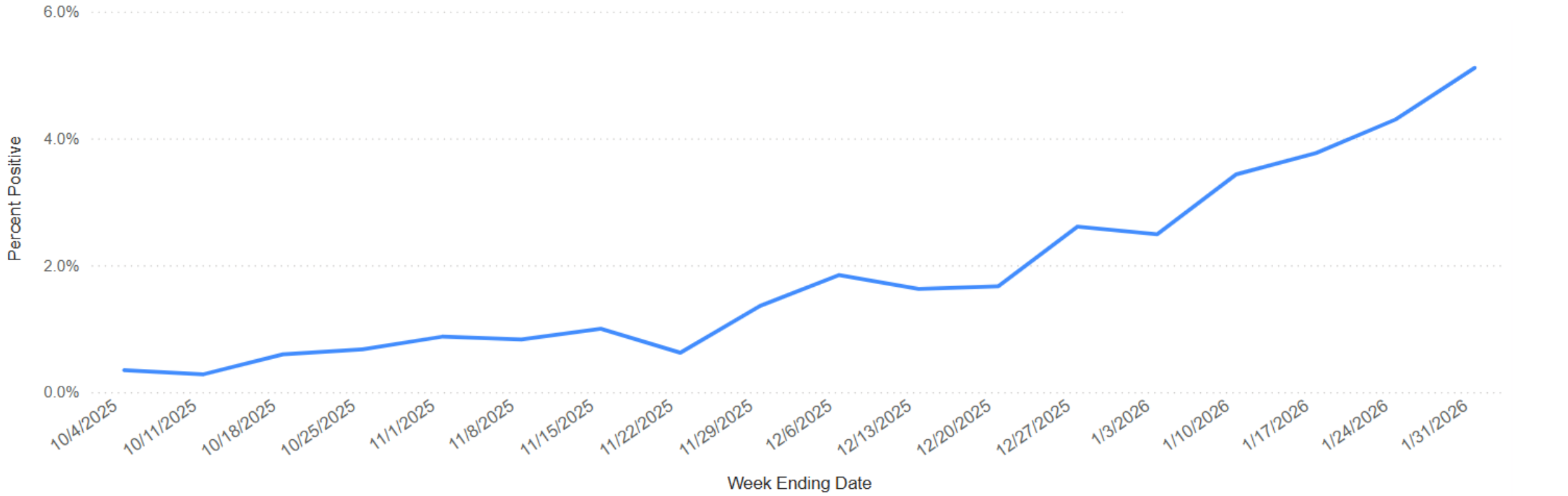


WASTEWATER SCAN

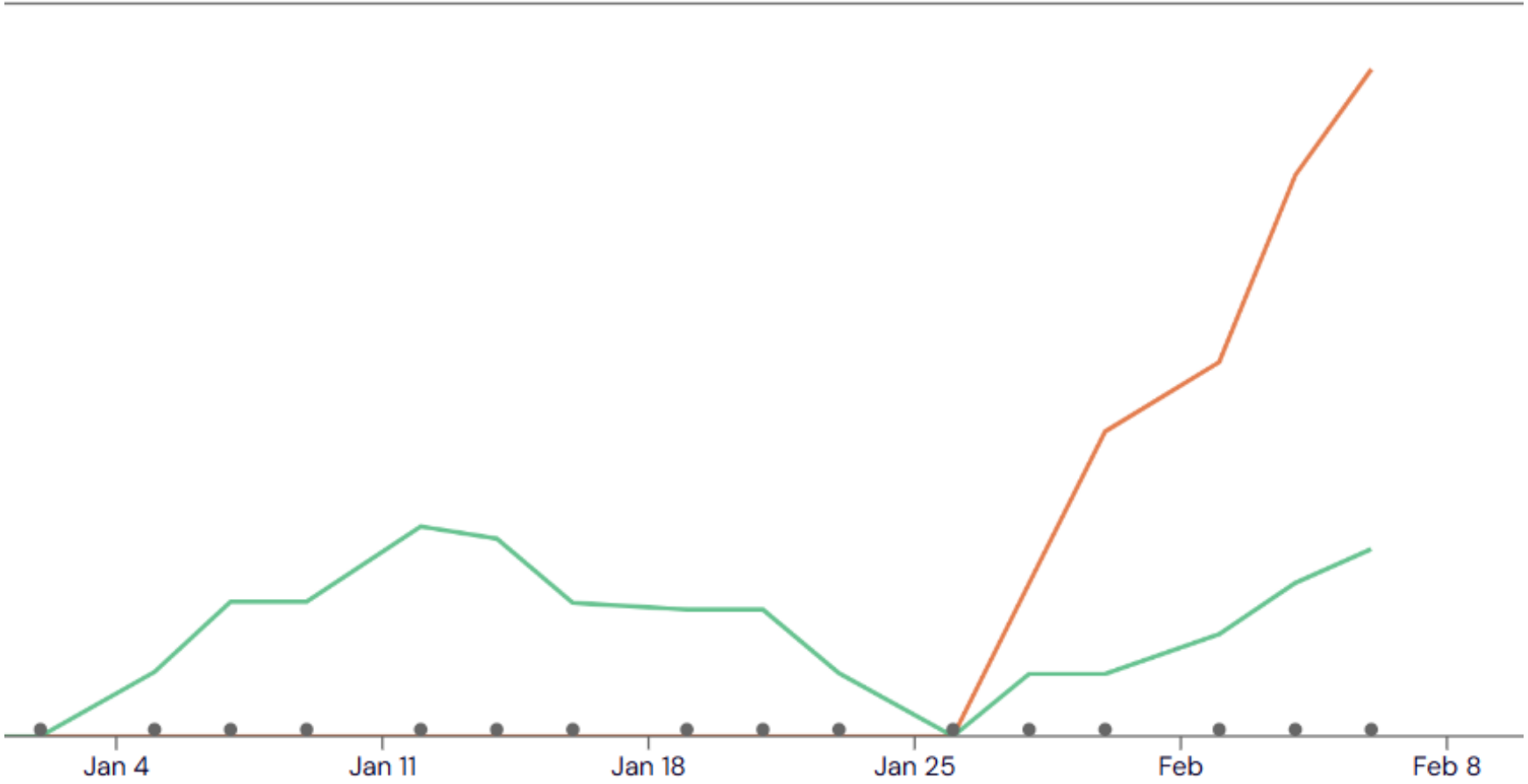
NE ICAP

RSV Percent Positive

Respiratory Season	Week Ending Date	MMWR Week	Percent Positive
2025-26	1/31/2026	4	5.1%



RSV Wastewater Data



Nebraska

- Northeast, Lincoln, NE (Northeast Water Resource Recovery Facility)
- Theresa Street, Lincoln, NE (Theresa Street Water Resource Recovery Facility)

National Healthcare Safety Network (NHSN)

The Hemovigilance Module

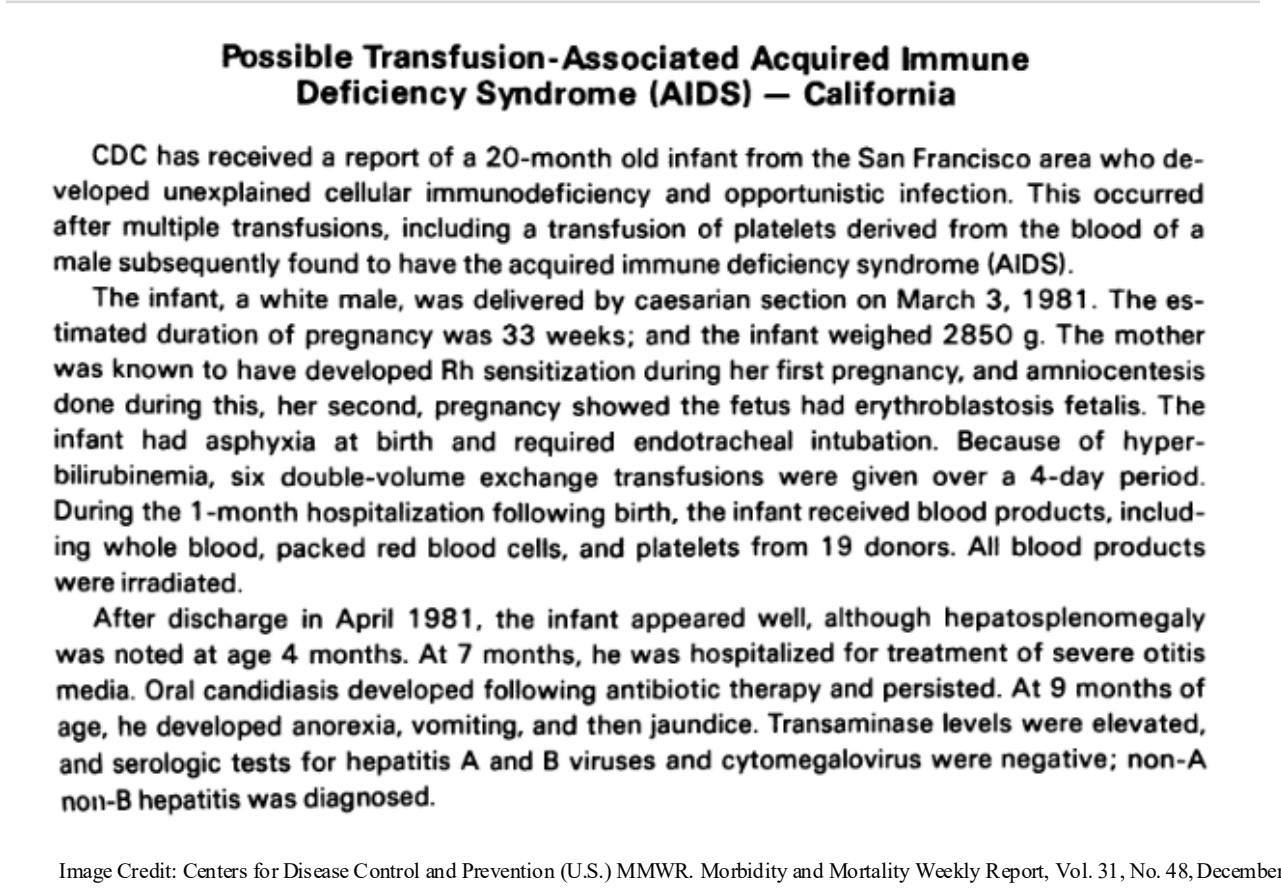
Isabel Griffin, PhD, MPH
Epidemiologist - NHSN Hemovigilance Module
Division of Healthcare Quality Promotion
National Center for Emerging and Zoonotic Infectious Diseases

Transfusion-associated adverse reactions can be severe and result in death.

In the United States, hemovigilance is inadequate:

- No requirement for transfusing hospitals to report transfusion-transmitted infections (TTIs) or other serious acute transfusion reactions to the Hemovigilance Module
- Transfusion history is not a required field on most case report forms for nationally notifiable diseases
- Ongoing risk of emerging pathogens in the U.S. blood supply

HIV was spreading through the blood supply.



Possible Transfusion-Associated Acquired Immune Deficiency Syndrome (AIDS) — California

CDC has received a report of a 20-month old infant from the San Francisco area who developed unexplained cellular immunodeficiency and opportunistic infection. This occurred after multiple transfusions, including a transfusion of platelets derived from the blood of a male subsequently found to have the acquired immune deficiency syndrome (AIDS).

The infant, a white male, was delivered by caesarian section on March 3, 1981. The estimated duration of pregnancy was 33 weeks; and the infant weighed 2850 g. The mother was known to have developed Rh sensitization during her first pregnancy, and amniocentesis done during this, her second, pregnancy showed the fetus had erythroblastosis fetalis. The infant had asphyxia at birth and required endotracheal intubation. Because of hyperbilirubinemia, six double-volume exchange transfusions were given over a 4-day period. During the 1-month hospitalization following birth, the infant received blood products, including whole blood, packed red blood cells, and platelets from 19 donors. All blood products were irradiated.

After discharge in April 1981, the infant appeared well, although hepatosplenomegaly was noted at age 4 months. At 7 months, he was hospitalized for treatment of severe otitis media. Oral candidiasis developed following antibiotic therapy and persisted. At 9 months of age, he developed anorexia, vomiting, and then jaundice. Transaminase levels were elevated, and serologic tests for hepatitis A and B viruses and cytomegalovirus were negative; non-A non-B hepatitis was diagnosed.

Image Credit: Centers for Disease Control and Prevention (U.S.) MMWR. Morbidity and Mortality Weekly Report, Vol. 31, No. 48, December 10, 1982

Hemophiliacs were being diagnosed with AIDS at an alarming rate.

How many…

“How many people [with hemophilia] have to die? Is three enough? Is six? Is ten? Is a hundred enough? Just give us the number so we can set the threshold!”

- CDC official Don Francis

The meeting produced no recommendations or changes.

Research News

Health Officials Seek Ways to Halt AIDS

A recent workshop considered the options for preventing the spread of the new immune disease; an easy solution is unlikely

On 4 January the Centers for Disease Control (CDC) convened a workshop at its Atlanta headquarters to assess the options for halting the spread of the new disease called acquired immunodeficiency syndrome or, more commonly, AIDS. The main topic of discussion was the possibility that the disease, which may kill up to 70 percent of the patients within 2 years of diagnosis, might be spread in blood and blood products.

The CDC recently reported that hemophiliacs are at high risk of contracting AIDS, which may be transmitted by an infectious agent in the blood clotting factor preparations that they take (*Science*, 7 January, p. 42). The Center's Bruce Evatt told the workshop that AIDS was the second leading cause of death for hemophiliacs in 1982, even though the disease was first discovered in hemophiliacs in the summer of that year. Eight hemophiliacs who had none of the other known risk factors died from AIDS, compared to some 40 who died of bleeding. James Curran, head of the CDC task force investigating AIDS, says, "The sense of urgency is greatest for hemophiliacs. The risk for others [who receive blood products] now appears small, but is unknown."

Suspicion has been cast on blood products in addition to clotting factor, however. An infant contracted AIDS after receiving red blood cells that had come from a man who developed the disease several months after he donated the blood. The CDC is also investigating the cases of two adults who developed AIDS after receiving blood transfusions during surgery. The two did not belong to any of the known high-risk groups, which include, in addition to hemophiliacs, homosexual and bisexual men who are extremely active sexually, users of intravenous drugs, and Haitians. In each case, investigators have identified a blood donor who has certain characteristics associated with AIDS, including a particular immune defect, although neither donor has actually developed the disease.

The CDC investigators have also identified several AIDS patients who donated blood. None of the recipients has contracted the condition, but there is still cause for worry. Thomas Spira of the CDC points out that there may be a long lag period, a year or more, between the time of exposure to the causative agent and the onset of AIDS. In other words, although there is currently no firm evidence linking ordinary blood transfusions to transmission of the disease, it is too early to rule out such a link.

The workshop participants easily reached agreement on some preventive measures that might check the spread of AIDS. About 75 percent of the AIDS victims are homosexual or bisexual men in whom the disease is thought to be sexually transmitted. There was general agreement that homosexual men should avoid sexual contact with known or suspected AIDS patients, minimize the number of their sexual partners, and refrain from anonymous sexual contacts. Heterosexuals might follow the same suggestions because, according to Curran, there are indications that AIDS may also be transmitted by heterosexual sex and other forms of intimate personal contact, such as that between mother and child.

> "The sense of urgency is greatest for hemophiliacs. . . ."

The seriousness of the threat of AIDS transmission by blood products and what, if anything, ought to be done in the current state of uncertainty remained thorny issues for the workshop participants. Not everyone agrees with the conclusion, accepted by CDC officials and many other investigators, that AIDS is caused by an infectious agent, presumably a virus, which could contaminate blood products. Louis Aledort, the medical director of the National Hemophilia Foundation, says, "I think it is too easily concluded that there is a transmissible agent. I can't rule it out but the data are not there yet." Aledort favors the idea that hemophiliacs, as well as homosexuals and intravenous drug users, because they are exposed to a great number of foreign antigens, experience a high degree of antigenic stimulation that effectively wears out their immune systems.

Nevertheless, because of the seriousness of AIDS, many participants were in favor of introducing measures to prevent persons who might be carrying an infectious agent from donating blood or plasma. The question is how to do this, especially in view of the long latent period of the disease and the possibility that many individuals who do not have full-blown AIDS may have a milder form or be asymptomatic carriers of an infectious agent.

Asking members of high-risk groups to voluntarily refrain from donating blood is one relatively uncontroversial approach, although it would probably not eliminate all potential carriers. Automatically excluding all members of high-risk groups is another, although this measure has the disadvantage of stigmatizing all homosexual males when only a fraction—those who are extremely sexually promiscuous—are likely to transmit an AIDS agent. Past and present users of intravenous drugs, who may be hepatitis carriers, and hemophiliacs are already excluded. Potential donors may also be screened for AIDS symptoms through a physical examination or a medical history.

Finally, the blood itself may be screened. Since the agent has not been identified, it would be necessary to use a "surrogate agent" as a marker for AIDS infectivity. The best candidate for this is an antibody to the core antigen of the hepatitis B virus. According to Spira, testing for this antibody in donated blood would detect about 90 percent of the donors who might transmit an AIDS agent, including persons with full-blown AIDS, those with the milder symptoms, and members of high-risk groups.

Some workshop participants favored requiring the test for all blood collection centers, but Aaron Kellner of the New York Blood Center dissented. "It is one thing to do these tests in the laboratory and another in the real world," he said. Kellner suggests that a few blood collection centers in the cities where AIDS is most prevalent—New York, San Francisco, and Los Angeles—undertake pilot

21 JANUARY 1983

271

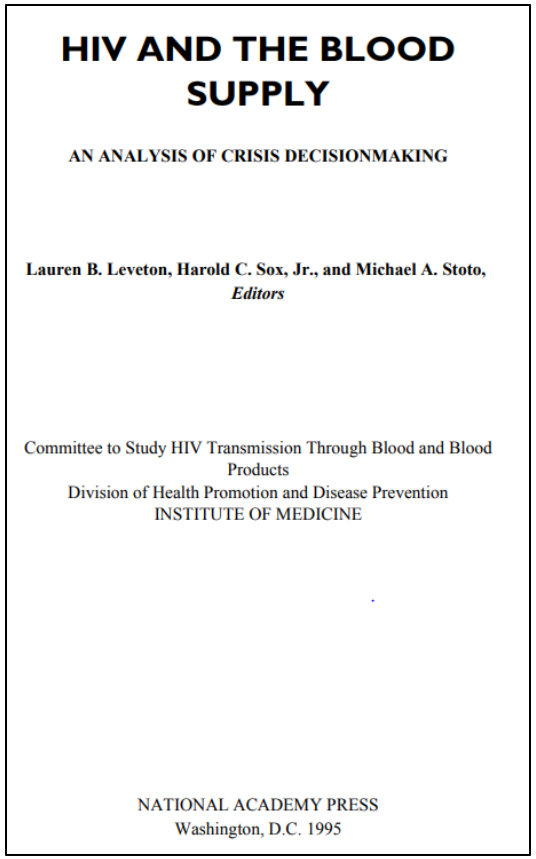
Image credit: Hemophilia Federation of America. Retrieved from History of Bleeding Disorders - Hemophilia Federation of America accessed on 5/15/25.

Institute of Medicine

- The Secretary of the Department of Health and Human Services (DHHS) asked a Committee of the Institute of Medicine (IOM) to review the scientific evidence that was available to decisionmakers during the early 1980s when the AIDS epidemic emerged, to examine the decision-making processes, and to evaluate the actions taken to contain the epidemic

- In 1995, the committee published 2 recommendations for CDC:

  - The PHS should establish a surveillance system, within CDC, that will detect, monitor, and warn of adverse effects in the recipients of blood and blood products.


HIV AND THE BLOOD SUPPLY

AN ANALYSIS OF CRISIS DECISIONMAKING

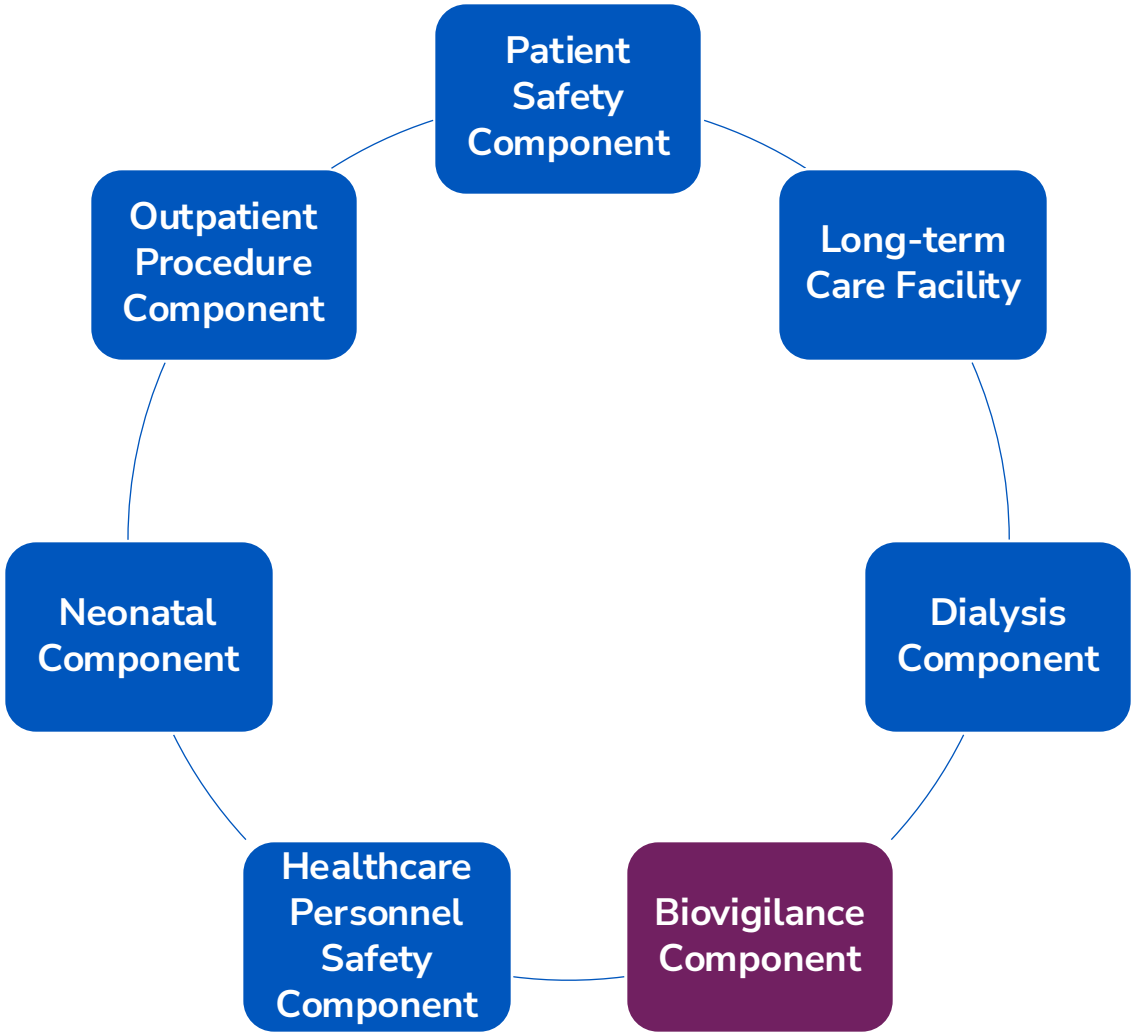
Lauren B. Leveton, Harold C. Sox, Jr., and Michael A. Stoto, *Editors*

Committee to Study HIV Transmission Through Blood and Blood Products
Division of Health Promotion and Disease Prevention
INSTITUTE OF MEDICINE

NATIONAL ACADEMY PRESS
Washington, D.C. 1995

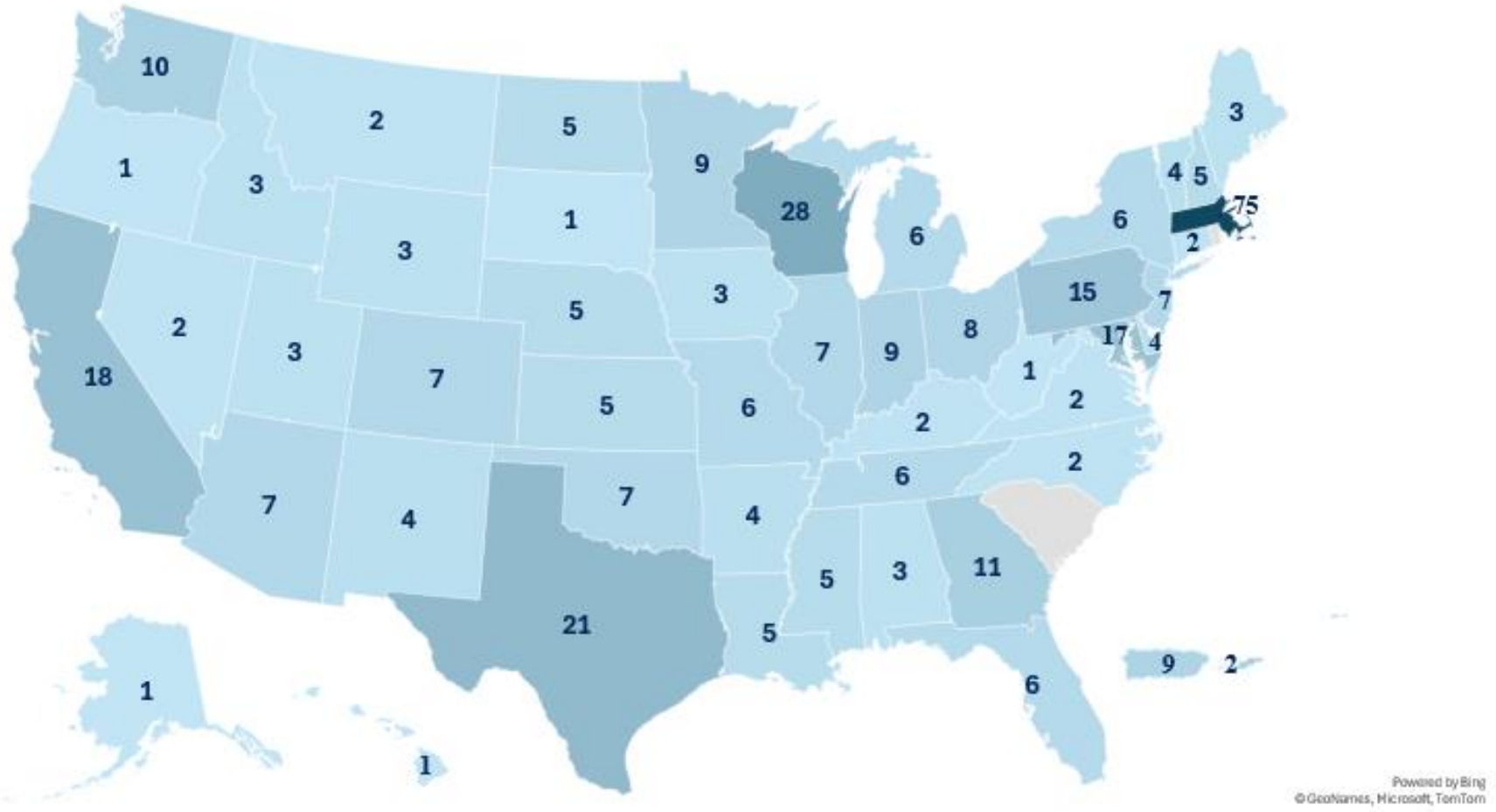
References: Institute of Medicine (US) Committee to Study HIV Transmission Through Blood and Blood Products. *HIV And The Blood Supply: An Analysis Of Crisis Decisionmaking*. Edited by Lauren B. Leveton et. al., National Academies Press (US), 1995. doi:10.17226/4989; Institute of Medicine. Emerging Infections. Washington, D.C.: National Academy Press, 1992.

National Healthcare Safety Network (NHSN)



The Biovigilance Component - Hemovigilance Module serves as the only national surveillance platform for recipient hemovigilance.

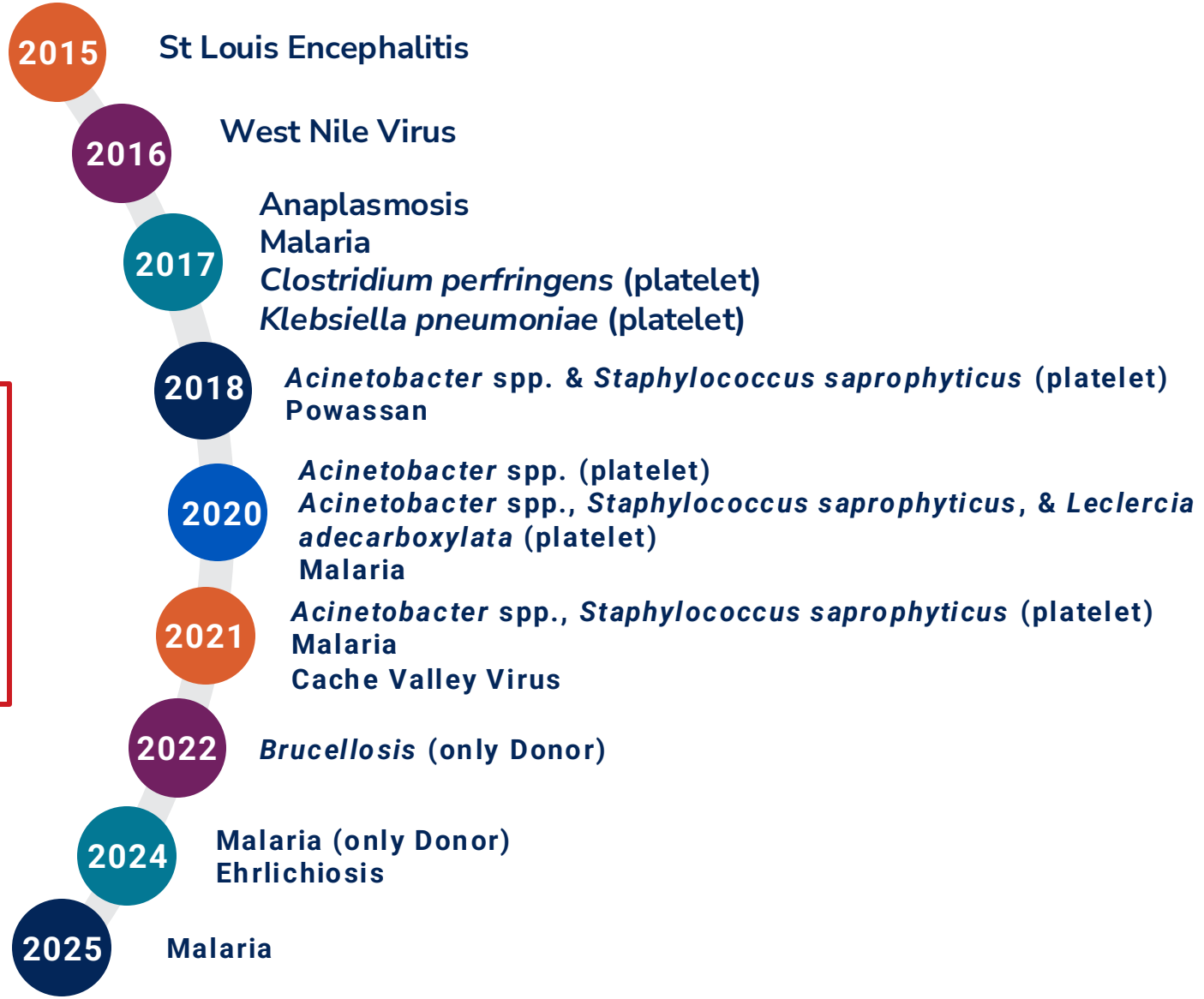
Facilities enrolled in NHSN Hemovigilance Module, November 2025



- **379/5,948 facilities are actively enrolled** in the Hemovigilance Module
- **Only 3 TTIs** were reported in 2025

TTI investigations by CDC over the years, 2015-2025

None of these were reported through the Hemovigilance Module – it is likely that serious TTIs may be unrecognized.



The NHSN Hemovigilance Module

Hemovigilance Module v2.9

Hemovigilance Module v3.0

Annual Acute Care Facility Survey
Annual Facility Survey Non-Acute Care Facility

→ **Annual Facility Survey**
(one form instead of two)

Anticipated January 2026

Adverse Reactions
AHTR
TACO
TRALI
Other Transfusion Reaction

Adverse Reactions
Transfusion Transmitted Infection (TTI)

→ **Adverse Reaction Investigation Form**
(one form instead of four)

→ **TTI Rapid Alert** + **TTI Investigation Form**

Anticipated March 2026

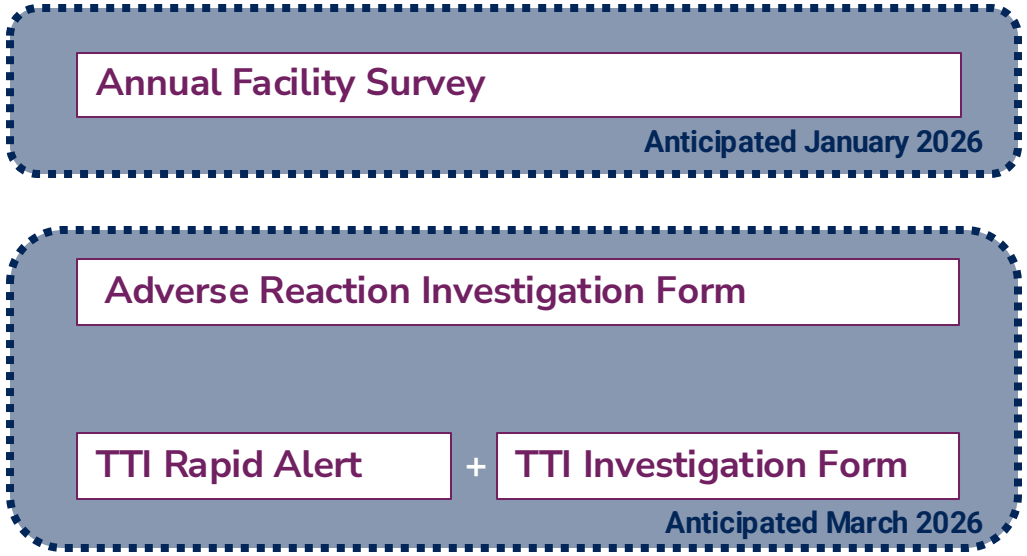
Monthly Reporting Plan	ATR
Monthly Reporting	HTR
Denominators	FNHTR
Incident Form	DSTR
Monthly Incident	TAGVHD
Summary	PTP
DHTR	Unknown Transfusion
TAD	Reaction

→ **No longer reported to Hemovigilance Module**

Abbreviations: AHTR, acute hemolytic transfusion reaction; DHTR, delayed hemolytic transfusion reaction; TACO, transfusion-associated circulatory overload; TRALI, transfusion-related acute lung injury; TTI, transfusion transmitted infection; TAD, transfusion-associated dyspnea; ATR, allergic transfusion reaction; HTR, hypotensive transfusion reaction; FNHTR, febrile non-hemolytic transfusion reaction; DSTR, delayed serologic transfusion reaction; TAGVHD, transfusion-associated graft versus host disease; PTP, post-transfusion purpura.

Would this be a lot of work for your facility?

Hemovigilance Module v3.0



- 1 submission annually
- Est. 30 minutes

- Submission based on occurrence
- TACO: 19.3 per 100,000 transfusions[1]
- TRALI: 1.0 per 100,000 transfusions[1]
- AHTR: 1.66 per 100,000 transfusions[1]
- Est. 20 minutes/occurrence

- Submission based on occurrence
- TTI ~0.25 per 100,000 transfusions[1*]
- Rapid Alert: Est. 5 min/occurrence
- TTI Investigation Form: Est. 60 min/occurrence

These 4 reactions (Acute Circulatory Overload, Acute Lung Injury, Acute Hemolytic, and Transfusion-Transmitted Infections) are rare.

There may be years where a facility may not have any to report to the module.

[1]Griffin IS, Kracalik I, McDavid K, et al. Supplemental findings of the 2023 National Blood Collection and Utilization Survey. Transfusion. Published online August 1, 2025. doi:10.1111/trf.18336
*May vary by pathogen

HEMOVIGILANCE MODULE V3.0

CDC's NEW Annual Facility Survey

- Facility characteristics
- Electronic monitoring of transfusions and adverse events
- Total units transfused by blood component

HEMOVIGILANCE MODULE V3.0

CDC's NEW Adverse Reaction Investigation Form

Simplified to one form for TACO, TRALI, AHTR or Other Transfusion Reaction

- Recipient Information
- Adverse Reaction Details
- Clinical Presentation
- Treatment
- Outcome
- Laboratory Test Results
- Investigation Findings

Proposed TTI Reporting Structure

4 Health Department works with facility to complete the TTI investigation form and submits to NHSN.

5 CDC identifies emerging threats to blood supply.

*Pathogens of Interest

Viruses: Cache Valley, Colorado tick fever, Dengue, Eastern Equine Encephalitis Hepatitis A, Hepatitis E, Japanese Encephalitis, Oropouche, Powassan, St. Louis encephalitis, Tick-borne encephalitis, Chikungunya, Yellow Fever, Zika.
Bacteria: *Acinetobacter baumannii*, *Anaplasma phagocytophilum*, *Brucella* spp., *Coxiella burnetii* (Q Fever), *Ehrlichia* spp., *Leclercia adecarboxylata*, *Rickettsia rickettsii*.
Parasites: *Babesia* spp., *Leishmania* spp., *Plasmodium* spp. (Malaria).

HEMOVIGILANCE MODULE V3.0

CDC's NEW TTI Rapid Alert Form

Hemovigilance Module
Transfusion Transmitted Infection (TTI)
Rapid Alert Form

*Required fields

***Facility ID#:** _____ ***Reporter Name:** [Dropdown based on current Facility users]

***Medical Record #:** _____ ***State of Residence:** ____

* ☐ **Pathogen of interest[1] has been detected: [Multiselect Dropdown – Pathogens of Interest]**

* ☐ **Patient received a transfusion in the 30 days prior to symptom onset or infection identification**

[1]Pathogens of Interest:

Viruses: Cache Valley virus, Colorado tick fever virus, Dengue virus, Eastern Equine Encephalitis virus, Hepatitis A virus, Hepatitis E virus, Japanese Encephalitis virus, Oropouche virus, Powassan virus, St. Louis encephalitis virus, Tick-borne encephalitis virus, Chikungunya virus, Yellow Fever virus, Zika virus.

Bacteria: *Acinetobacter baumannii*, *Anaplasma phagocytophilum*, *Brucella* spp., *Coxiella burnetii* (Q Fever), *Ehrlichia* spp., *Leclercia adecarboxylata*, *Rickettsia rickettsii*.

Parasites: *Babesia* spp., *Leishmania* spp., *Plasmodium* spp. (Malaria).

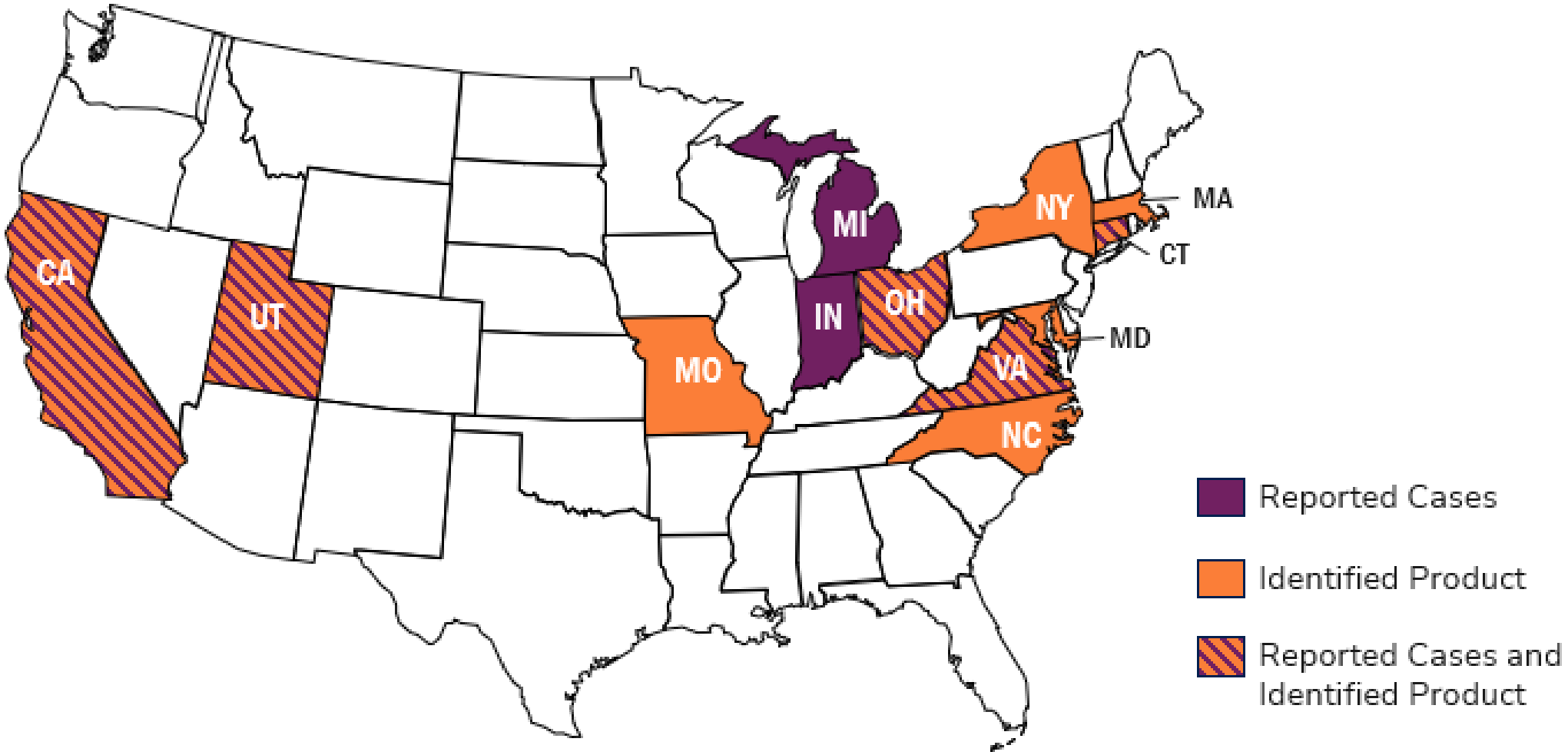
HEMOVIGILANCE MODULE V3.0

CDC’s Updated TTI Investigation Form

- Patient Information
- Patient Medical History (reason for transfusion)
- Adverse Reaction Details
- Laboratory Test Results
- Signs and Symptoms
- Patient Treatment
- Recipient Epidemiologic Risk Assessment (to rule out transfusion)
- Component Details (ISBT-128 product codes, pathogen detected)
- Donor Investigation (mosquito or tick exposures, travel history)
- Investigation Findings (Case Definition, Severity, Imputability)
- Facility Investigation Notes
- CDC Investigation Notes

Nationwide platelet contamination

CDC and FDA identified 8 cases and 20 contaminated products in 12 states.

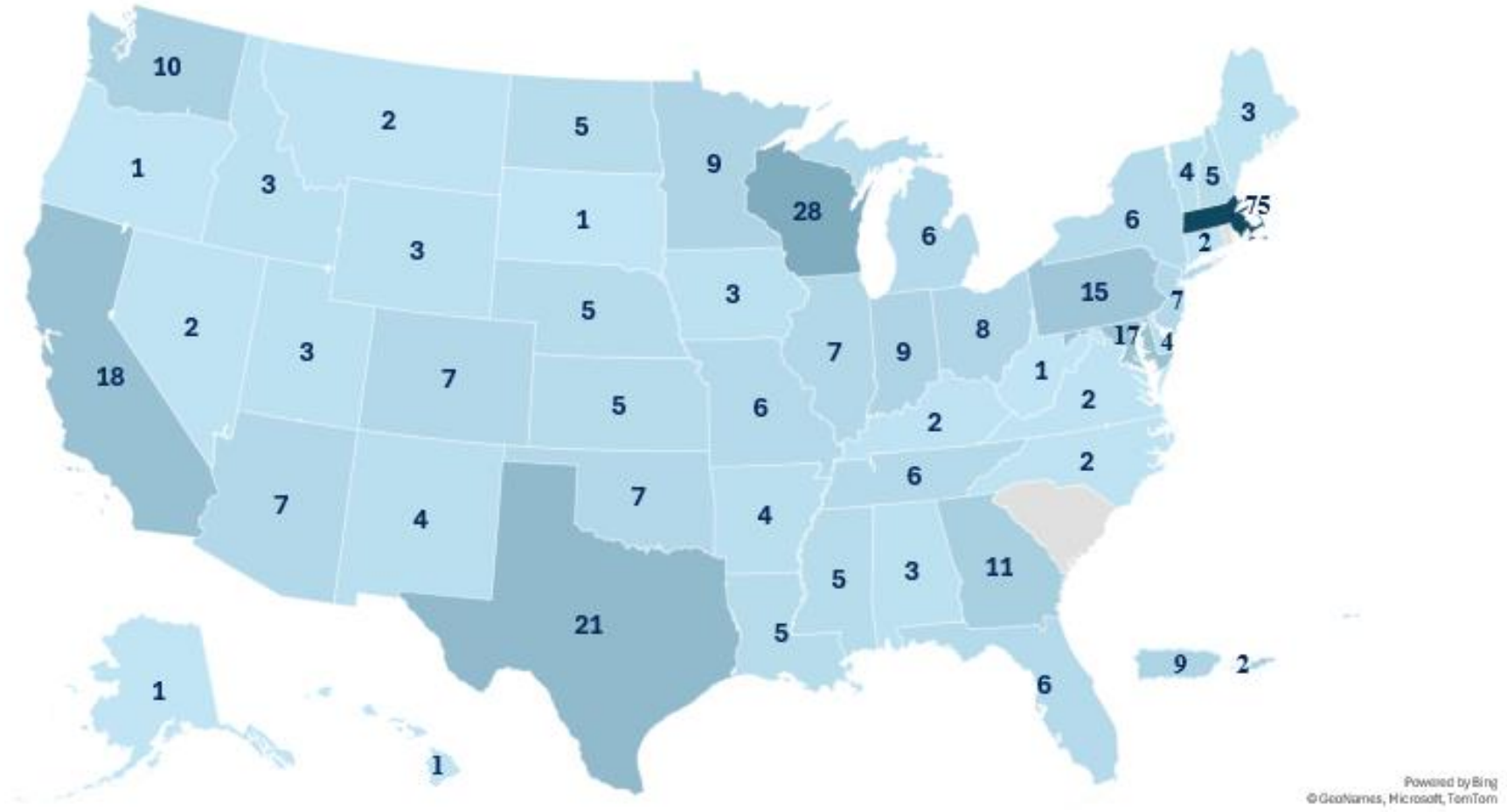


Nationwide platelet contamination

Investigation Findings

- **Environmental isolates** from the bag manufacturing facilities were **genetically related** to clinical **sepsis cases and contaminated products.**
- Issues with **collection set sterility** were observed during inspection of a manufacturing facility.

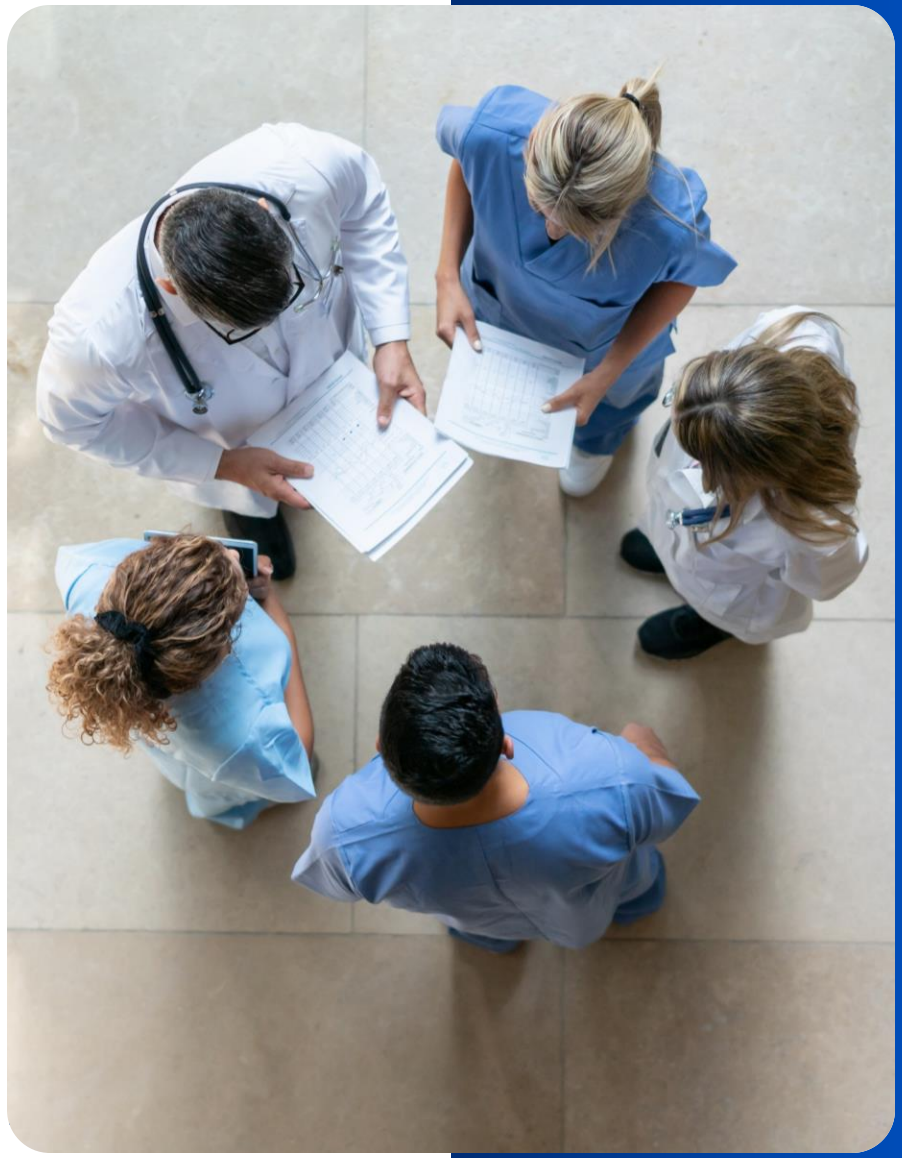
Currently, do we think the module would provide an early warning system for a similar outbreak?



379/5,948 facilities are actively enrolled in the Hemovigilance Module

Benefits of Healthcare Facility Participation

- Early warning system for emerging pathogens
- Facilities can systematically track the safety of transfusions
- Save lives through rapid reporting and investigation of TTIs
- Nationwide estimates of serious adverse reactions



What you can do now

- Activate the BV component for your facility.
  - Join our monthly office hours: 1/27 and 2/24
- Submit your Annual Facility Survey.
- Report via TTI Rapid Alert in March.

Want more information?

Email our team directly at **hemovigilance@cdc.gov**.

For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 https://www.cdc.gov/
Follow us on social **@CDCgov**

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the U. S. Centers for Disease Control and Prevention.

Surgical Site Infection (SSI) Case Reviews & Engagement of the SSI Prevention Team for Quality Improvement

Rebecca Martinez, BSN, BA, RN, CIC
Infection Preventionist, NE ICAP

NE ICAP

Learning Objectives

- Describe the importance of an SSI surveillance plan
- Outline the difference between SSI reporting and SSI reviewing
- Identify where to find NHSN training and resources
- Review an SSI case scenario and assess any practice gaps
- List at least one strategy that could be used to promote physician engagement within the SSI prevention team

Importance of SSI Surveillance

- SSI prevention should be a priority patient safety issue
  - SSIs are a substantial cause of patient morbidity and mortality
- SSI are costly to the healthcare system
- About half or more of SSIs are estimated to be preventable
- Surveillance of SSI with feedback of data is important for prevention efforts and to reduce the risk of SSI
  - Using standardized SSI criteria applied in the same manner allows the use of data for epidemiological purposes
  - Monitoring over time can help inform trends and quality improvement activities

The hospital must have active hospital-wide programs for the surveillance, prevention, and control of HAIs and other infectious diseases, and for the optimization of antibiotic use through stewardship. – CMS Condition of Participation §482.42 and §485.640

2026 NHSN PSC Manual

2026 Live NHSN PSC Annual Training Series

2026 Patient Safety Component Annual Training Series, designed to enhance your NHSN reporting knowledge. Whether you're new to NHSN or looking to expand your expertise, these sessions are designed to help you succeed. This training will include content relating to the Patient Safety Component, the Outpatient Procedure Component, digital quality measures, and analytics.

Live virtual training sessions begin March 17, 2026, and will include interactive Q&A. Sessions will start at 12 noon Eastern Time. Please plan to join live as there will be no replay of the training sessions. Meeting details will be provided soon.

- **Training Week 1** – March 17 and March 19
- **Training Week 2** – March 24 and March 26
- **Training Week 3** – March 31 and April 2
- **Training Week 4** – April 7

Watch for emails from NHSN with details including a preparation webinar 2/18/26 at 2:00 Eastern Time PSC 2026 Annual Training Preparation: Know Before You Go

Planned Training Topics: (complete agenda closer to training)

Antimicrobial Use and Resistance
Device-associated Events
Digital Quality Measures (dQMs)
MRSA Bacteremia and C. difficile LabID events
Outpatient Procedures
Surgical Site Infection Events
New Initiatives

NHSN Annual Training

ICAP

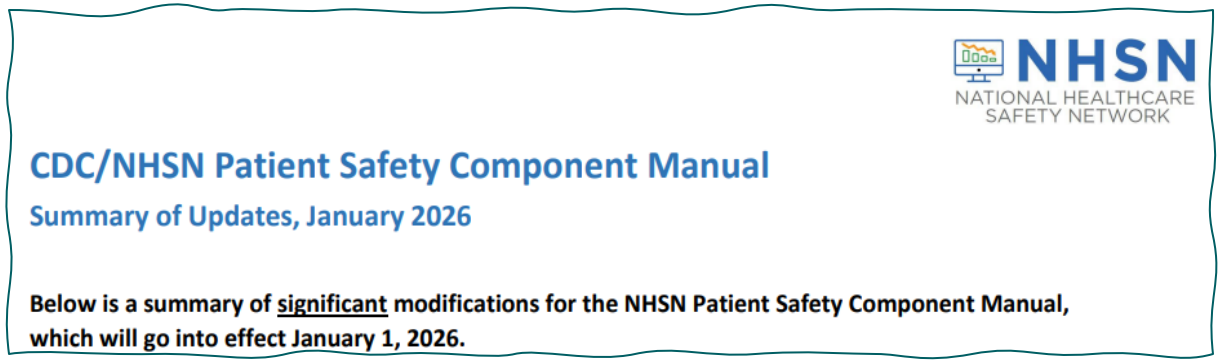
2026 NHSN PSC Manual & Updates

- 2026 NHSN PSC Manual
  - Annual updates to manual
- CDC/NHSN PSC Manual - SUMMARY of Updates, January 2026
  - Summary document
  - Remember that updates in general chapters will therefore impact the specific device and event modules (i.e. SSI Event module)
- NHSN application updates
  - Released within the application and sometimes delayed


NHSN
NATIONAL HEALTHCARE SAFETY NETWORK

January 2026

National Healthcare Safety Network (NHSN)
Patient Safety Component Manual


NHSN
NATIONAL HEALTHCARE SAFETY NETWORK

CDC/NHSN Patient Safety Component Manual

Summary of Updates, January 2026

Below is a summary of significant modifications for the NHSN Patient Safety Component Manual, which will go into effect January 1, 2026.


My Applications

National Healthcare Safety Network System

- NHSN Reporting *
- NHSN Enrollment *

ICAP

Surgical Site Infection Event (SSI)

Table of Contents

Chapter 9: SSI Event

- 2026 NHSN PSC Manual
  - Chapter 9 = Surgical Site Infection (SSI) Event
    - Pages 9 – 1 to 9 – 43 (PDF 124-166)

ICAP

2026 SSI Checklist

- 2026 NHSN SSI Checklist

Surgical Site Infection (SSI)
Superficial incisional SSI (SIP, SIS)

Surgical Site Infection (SSI)
Deep incisional SSI (DIP, DIS)

Surgical Site Infection (SSI)
Organ/Space SSI (O/S)

2026 NHSN Surgical Site Infection (SSI) Checklist

Surgical Site Infection (SSI) Documentation Review Checklist

Definition of an NHSN Operative Procedure

An NHSN Operative Procedure is a procedure:

- that is included in the ICD-10-PCS and/or CPT NHSN operative procedure code mapping

And

- takes place during an operation where at least one incision (including laparoscopic approach and cranial Burr holes) is made through the skin or mucous membrane, or entry is through an existing incision (such as an incision from a prior operative procedure)

And

- takes place in an operating room (OR), defined as a patient care area that met the Facilities Guidelines Institute's (FGI) or American Institute of Architects' (AIA) criteria for an operating room when it was constructed or renovated. This may include an operating room, C-section room, interventional radiology room, or a cardiac catheterization lab.

PROCEDURE DETAILS:

Date of NHSN Operative Procedure (start of SSI surveillance period): _____

ICD-10-PCS/CPT Operative Procedure Code(s) Assigned:

_____

NHSN Operative Procedure Category(ies) (COLO, HYST, etc.):

_____

SSI EVENT DETAILS:

Criterion	Criterion Met	Date of Event	Procedure of Attribution	PATOS
SIP	☐			
SIS	☐			
DIP	☐			
DIS	☐			
O/S	☐			

If O/S SSI, specify site-specific criteria met: _____

Please refer to Chapter 9 Surgical Site Infection (SSI) Event of the Patient Safety Manual for additional information.

Example SSI Case Scenario *(for educational purposes, not actual)*

- Mr. John Doe is a 64 yo patient with HTN, obesity with BMI of 56, sleep apnea, IDDM II with A1c of 7. He underwent a L total hip arthroplasty on January 1st of 2026 with no immediate complications.

- Review of the procedure includes:
  - Smoker: never smoker
  - Glycemic control: adequate A1c, well controlled on the immediate post-op period
  - Decolonized with 5 days of CHG and mupirocin BID
  - CHG wipes “nose to toes” on day of surgery performed
  - Surgical site clipped, not shaved
  - Prophylaxis: cefazolin 3g IV for 72 hours (infused 20 minutes before skin incision)
  - 10 days after surgery he noticed mild opening of his wound with serous drainage. Mild increase in pain. No fevers

Scenario Continued…

- 15 days post op admitted for revision:
  - Upon inspection of the previous surgical incision over the left hip, the majority of the wound appeared well-approximated. However, at the most distal aspect of the incision, there was an area of active seropurulent drainage, associated with hyperemia and erythema along the entire length of the incision. There was also palpable fluctuance, suggestive of subcutaneous fluid accumulation.

    We used our prior posterolateral incision. The skin and subcutaneous tissues were incised sharply. Upon entry, a copious amount of dark, cloudy fluid was encountered and immediately aspirated. A sample of the fluid was sent to the laboratory for gram stain, culture, and sensitivity testing. Further debridement of the subcutaneous tissues revealed the underlying fascia, which was largely intact except for a 2 cm × 0.5 cm dehisced area at the distal end of the incision that communicated directly with the joint space.

    At this point, decision made to proceed with formal debridement, followed by modular head and liner exchange.
  - DAIR is performed, multiple cultures were performed and returned negative.

Based on SSI Case Scenario – Example of an SSI Drill Down Review

SURGERY DATE	30 vs. 90 DAY	NHSN CODE	SURGERY	OR ROOM	DURATION	WOUND CLASS	PATOS	SSI TYPE	NHSN CRITERIA MET	ORGANISM(S)
1/1/2026	*90*	*HPRO*	*Left total hip arthroplasty*	*1*	*3 hours*	*C*	*no*			*negative*

DECOLONIZATION	HOME BATHING	HAIR REMOVAL	PRE-OP BATHING	PRE-OP ABX	SKIN PREP	TEMP > 35.5C	POST-OP GLUCOSE
mupirocin BID + CHG X 5 days		*clipper*	*CHG wipes nose to toes*	*cefazolin 3g IV for 72 hours (infused 20 minutes before skin incision)*	*CHG + Alcohol*	*yes*	*well controlled*

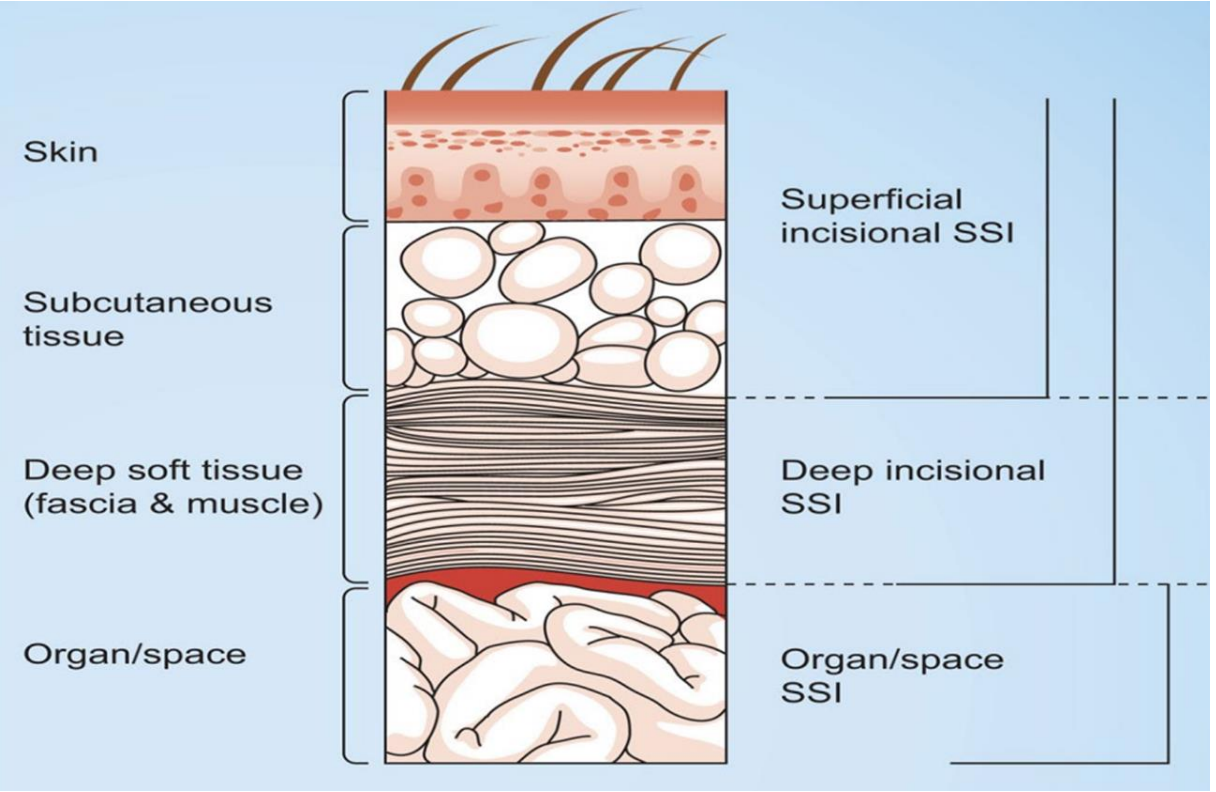
DIABETIC	BMI	IMMUNO-SUPPRESSED	CURRENT SMOKER	KEY NOTES
Type II (IDDM II) Pre-op HbgA1c 7	*56*	*no*	*never*	*BMI 56, revision s/p 15 days, communication to joint*

NE ICAP - SSI Review and Track - TEMPLATE

NE ICAP

Questions to Answer

- NHSN criteria met for HPRO SSI?
- If yes, what level / classification?
- Is this a PJI?
- Any practice gaps?
- Any trends?



CDC NHSN Classification for SSI Source: Anderson, et al

Organ/Space SSI

Must meet the following criteria:

Date of event occurs within 30 or 90 days following the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2

AND

involves the organ/space tissues (deeper than the fascia/muscle)

AND

patient has at least ***one*** of the following:

a. purulent drainage from a drain placed into the organ/space (for example, closed suction drainage system, open drain, T-tube drain, CT-guided drainage)
b. organism(s) identified from fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing [ASC/AST])
c. an abscess or other evidence of infection involving the organ/space detected on:
    - gross anatomical exam or
    - histopathologic exam or
    - imaging test evidence definitive or equivocal for infection

AND

meets at least ***one*** eligible [per Appendix A]criterion for a specific organ/space infection site listed in Table 3. These criteria are found in the Surveillance Definitions for Specific Types of Infections (Chapter 17).

Examples of gross anatomic evidence of organ/space infection:

- An intraabdominal abscess will require an invasive procedure to actually visualize the abscess.
- Visualization of pus or purulent drainage (includes from a drain).

PJI – Periprosthetic Joint Infection

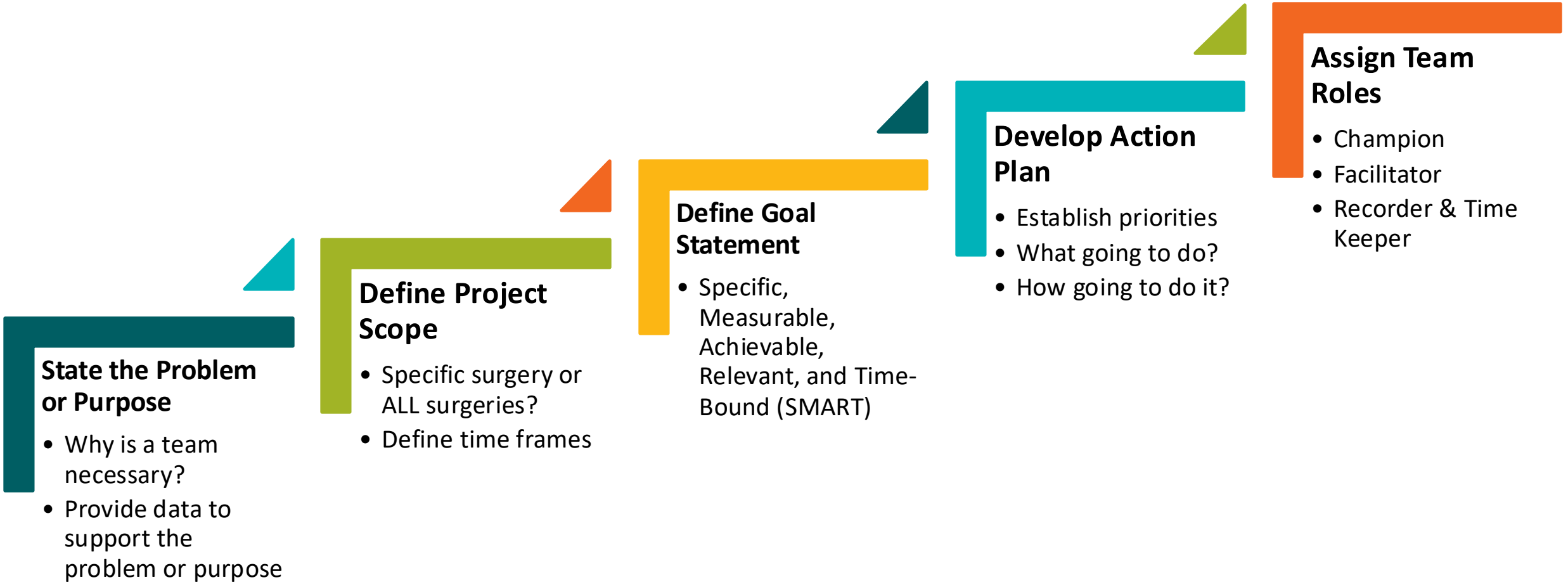
PJI – Periprosthetic Joint Infection (for use as Organ/Space SSI following HPRO and KPRO only)

Periprosthetic joint or bursa infections must meet at least ***one*** of the following criteria:

1. ***Two*** positive periprosthetic specimens (*tissue or fluid*) with at least one matching organism, identified by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).
2. A sinus tract* communicating with the joint, purulence, or other gross anatomic evidence of infection.
3. Having ***three*** of the following minor criteria:
    a. elevated serum C-reactive protein (CRP; >100 mg/L) ***and*** erythrocyte sedimentation rate (ESR; >30 mm/hr.)
    b. elevated synovial fluid white blood cell (WBC; >10,000 cells/µL) count *OR* "++" *(or greater)* change on leukocyte esterase test strip of synovial fluid.
    c. elevated synovial fluid polymorphonuclear neutrophil percentage (PMN% >90%)
    d. positive histological analysis of periprosthetic tissue (>5 neutrophils (PMNs) per high power field).
    e. organism(s) identified from a single positive periprosthetic specimen (*tissue or fluid*) by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).
    f. Synovial fluid alpha-defensin positive.
    g. Physician diagnosis of periprosthetic joint infection.

* A sinus tract is defined as a narrow opening or passageway that can extend in any direction through soft tissue and results in dead space with potential for abscess formation.

Establishing SSI Team Goals



Adapted from Michigan Surgical Quality Collaborative (MSQC) SSI Toolkit

Engaging Providers for SSI Quality Improvement

Discover Common Purpose

- Improve patient outcomes
- Reduce hassles and wasted time
- Understand the organization's culture

Reframe Values and Beliefs

- Make physicians (surgeons, anesthesiologists, etc.) partners not customers
- Promote both system and individual responsibility for quality

Segment the Engagement Plan

- Identify and activate front-line champions
- Educate and inform structural leaders
- Identify and work with those cautious or reluctant late adopters

Adapted from Reinertsen JL, Gosfield AG, Rupp W, Whittington JW. Engaging Physicians in a Shared Quality Agenda. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2007. (Available on www.IHI.org)

Engaging Providers for SSI Quality Improvement

Use “Engaging” Improvement Methods

- Standardize what is standardizable, …no more
- Generate light, not heat, with data (use data sensibly)
- Make the right thing easy to try and easy to do

Show Courage

- Provide backup all the to the board

Adopt an Engaging Style

- Involve physicians from the beginning
- Choose messages and messengers carefully
- Make physician involvement visible
- Communicate candidly, often building trust
- Value physicians’ time with your time

Adapted from Reinertsen JL, Gosfield AG, Rupp W, Whittington JW. Engaging Physicians in a Shared Quality Agenda. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2007. (Available on www.IHI.org)

Misc. Updates & Upcoming Educational Opportunities

Rebecca Martinez, BSN, BA, RN, CIC
Infection Preventionist, NE ICAP

NE ICAP

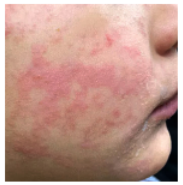
CDC Project Firstline Resource

Germs Can Live In Blood, Reduce Risk

- Ensure Hepatitis B vaccination
- Always use standard precautions
  - Hand hygiene
  - Proper use of PPE
  - Safe injection practices
  - Cleaning and disinfecting properly

CDC Project Firstline - Germs Can Live in Blood

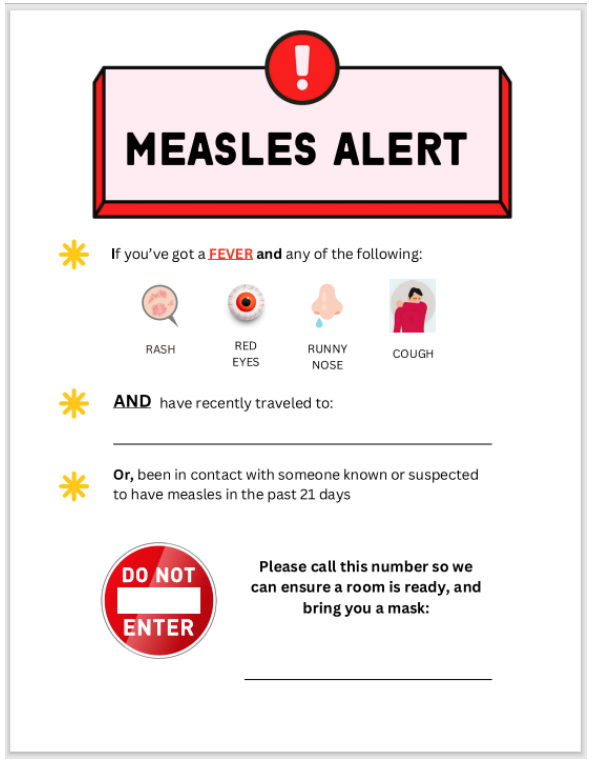
ICAP Measles Resources

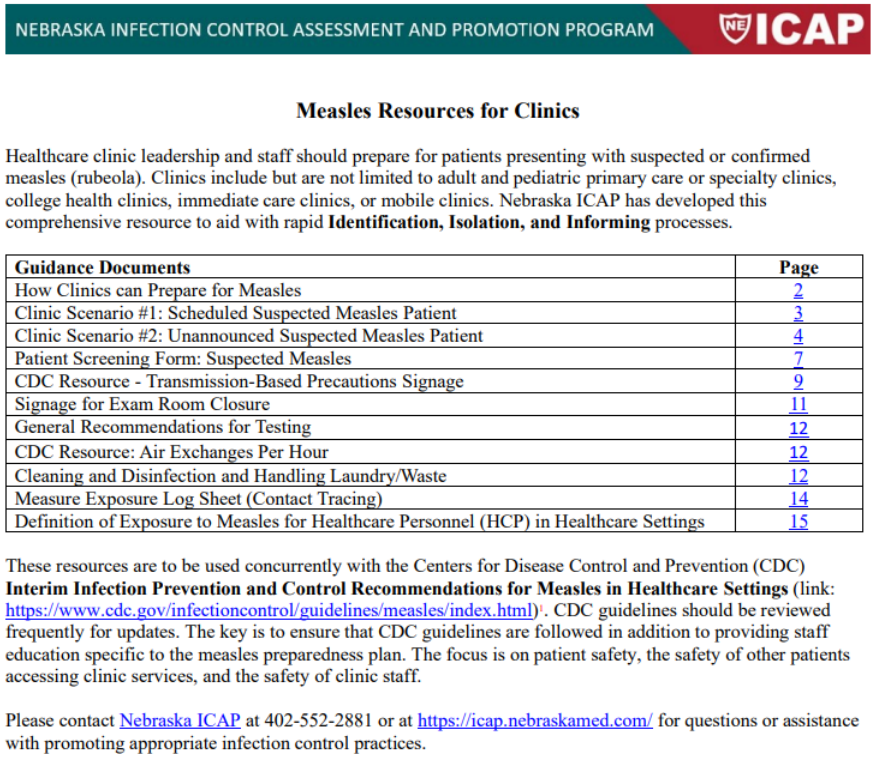


Nebraska Infection Control Assessment and Promotion Program (ICAP) is committed to supporting various healthcare settings for their infection prevention and control needs.

The following resources have been collected to help provide information regarding Measles (Rubeola).

For questions relating to a suspected case or current outbreak, please contact your local health department (LHD). If your LHD is not available, please call the Nebraska DHHS Epidemiology team at 402-471-2937.





NEBRASKA INFECTION CONTROL ASSESSMENT AND PROMOTION PROGRAM ICAP

Measles Resources for Clinics

Healthcare clinic leadership and staff should prepare for patients presenting with suspected or confirmed measles (rubeola). Clinics include but are not limited to adult and pediatric primary care or specialty clinics, college health clinics, immediate care clinics, or mobile clinics. Nebraska ICAP has developed this comprehensive resource to aid with rapid **Identification, Isolation, and Informing** processes.

Guidance Documents	Page
How Clinics can Prepare for Measles	2
Clinic Scenario #1: Scheduled Suspected Measles Patient	3
Clinic Scenario #2: Unannounced Suspected Measles Patient	4
Patient Screening Form: Suspected Measles	7
CDC Resource - Transmission-Based Precautions Signage	9
Signage for Exam Room Closure	11
General Recommendations for Testing	12
CDC Resource: Air Exchanges Per Hour	12
Cleaning and Disinfection and Handling Laundry/Waste	12
Measure Exposure Log Sheet (Contact Tracing)	14
Definition of Exposure to Measles for Healthcare Personnel (HCP) in Healthcare Settings	15

These resources are to be used concurrently with the Centers for Disease Control and Prevention (CDC) **Interim Infection Prevention and Control Recommendations for Measles in Healthcare Settings** (link: https://www.cdc.gov/infectioncontrol/guidelines/measles/index.html)[1]. CDC guidelines should be reviewed frequently for updates. The key is to ensure that CDC guidelines are followed in addition to providing staff education specific to the measles preparedness plan. The focus is on patient safety, the safety of other patients accessing clinic services, and the safety of clinic staff.

Please contact Nebraska ICAP at 402-552-2881 or at https://icap.nebraskamed.com/ for questions or assistance with promoting appropriate infection control practices.

https://icap.nebraskamed.com/pathogens-of-interest/measles/

Primary Infection Prevention Course

Track 1 (two-day): Prevention for All Health Care Settings, Acute Care Hospital, Ambulatory Care & Surgical Centers

Track 2 (two-day): Prevention for All Health Care Settings and Long-Term Care and Assisted Living Facilities

April 22 & 23, 2026
Holthus Convention Center
3130 Holen Ave., York, NE 68467

https://www.nicn.org/events/nicn-primary-infection-prevention-course

Objectives:

- Recognize the impact of emerging and reemerging infectious diseases including measles and other vaccine-preventable infections, syphilis, and tuberculosis.
- Identify strategies for the evaluation and treatment of common infectious syndromes including applications of molecular diagnostic testing.
- Describe the role of telemedicine and pretravel evaluations as part of comprehensive strategies to mitigate and address infections.

https://lifelong.creighton.edu/browse/all-courses/live/online/courses/id2026

NE ICAP

Infection Control Assessment & Response (ICAR) Visits

Surgical Site Infection Prevention

Sterilization

Safe Injection Practices

Environmental Cleaning & Disinfection

Hand Hygiene

High-Level Disinfection

Point of Care Blood Testing

Laundry

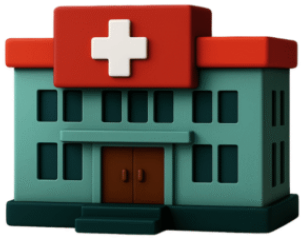
PPE & Standard Precautions

Indwelling Devices (e.g. CAUTI, CABSI)

Wound Care

Water Management

Transmission -Based Precautions



Join Us - Upcoming NE ICAP Webinars

- **Wednesday March 11, 2026**
  - 12:00 – 1:00 PM (CST)
    - Pharmacy Clean Rooms – What the IP Should Know
    - Jillian Mack, PharmD

- **Wednesday April 8, 2026**
  - 12:00 – 1:00 PM (CST)
    - Infection Control Essentials for the Clinical Laboratory
    - Kay Huff, MLS (ASCP), CIC

ICAP Contact Information

Call 402-552-2881

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

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

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

Webinar CE Process

- **1 Nursing Contact Hour is awarded by Nebraska ICAP**
  - Nebraska Infection Control Assessment and Promotion Program is approved as a provider of nursing continuing professional development by the VTL Center for Professional Development, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

- **CNE Nursing Contact Hours:**
  - Completion of survey is required.
  - The survey must be specific to the individual obtaining credit; (i.e., 2 people cannot be listed on the same survey).
  - Survey functionality is lost on mobile devices.
  - One certificate is issued quarterly for all webinars attended.
  - Certificate comes directly from ICAP via email.