Infection Prevention Webinar Series for Hospital & Outpatient Settings

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

September 9, 2026

NE ICAP

NEBRASKA INFECTION CONTROL ASSESSMENT AND PROMOTION PROGRAM

Presenters & Panelists

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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 VTL Center for Professional Development, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
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Questions & Answer Session

- Please use the Q&A box in the webinar platform to type your question so it can be read aloud.
- If your question is not answered during the webinar or you need one-on-one help, please call 402.552.2881 Monday to Friday, 8 a.m. to 4 p.m. CST, to speak with an Infection Preventionist.
- You can also email your question to nebraskaicap@nebraskamed.com

Slides & Webinar Recordings

- During the webinar: You can access the slides on the NE ICAP Hospital webpage
- After the webinar: The slides and the recording will be available under the Webinars tab on the Past Webinars and Slides page

Nebraska Pathogen Watch

Rebecca Martinez, BSN, BA, RN, CIC

Infection Preventionist, NE ICAP

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Key Points

- Measles continues to spread in areas across the country.
  - Currently, Nebraska is not reporting any measles cases.

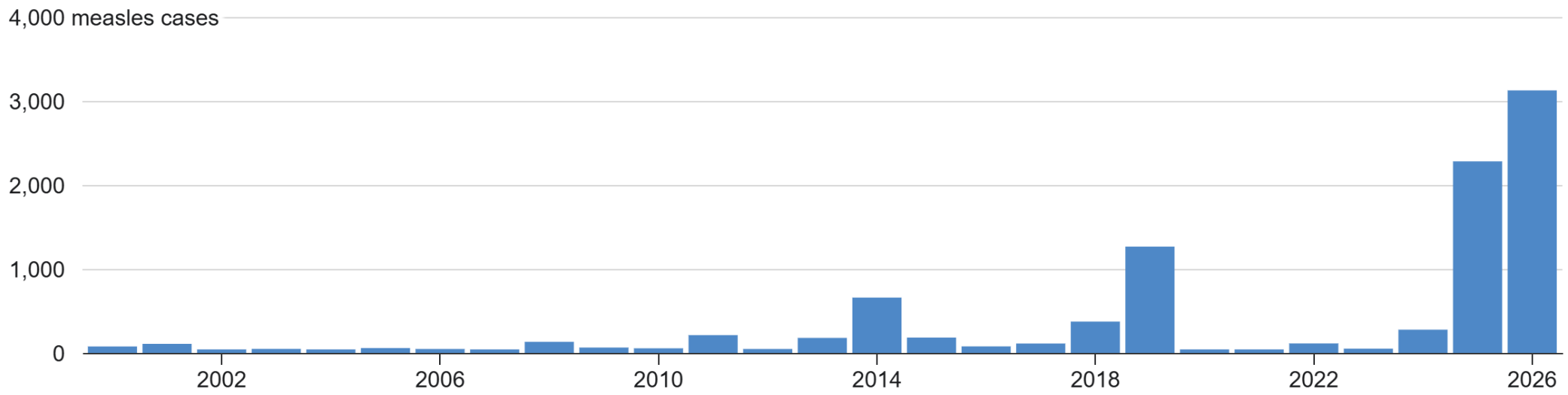
- Influenza, COVID-19, and RSV illness activity is currently very low.

Yearly Measles Cases

Yearly measles cases

as of September 3, 2026

2000-Present* 1985-Present*



CDC Measles Cases and Outbreaks

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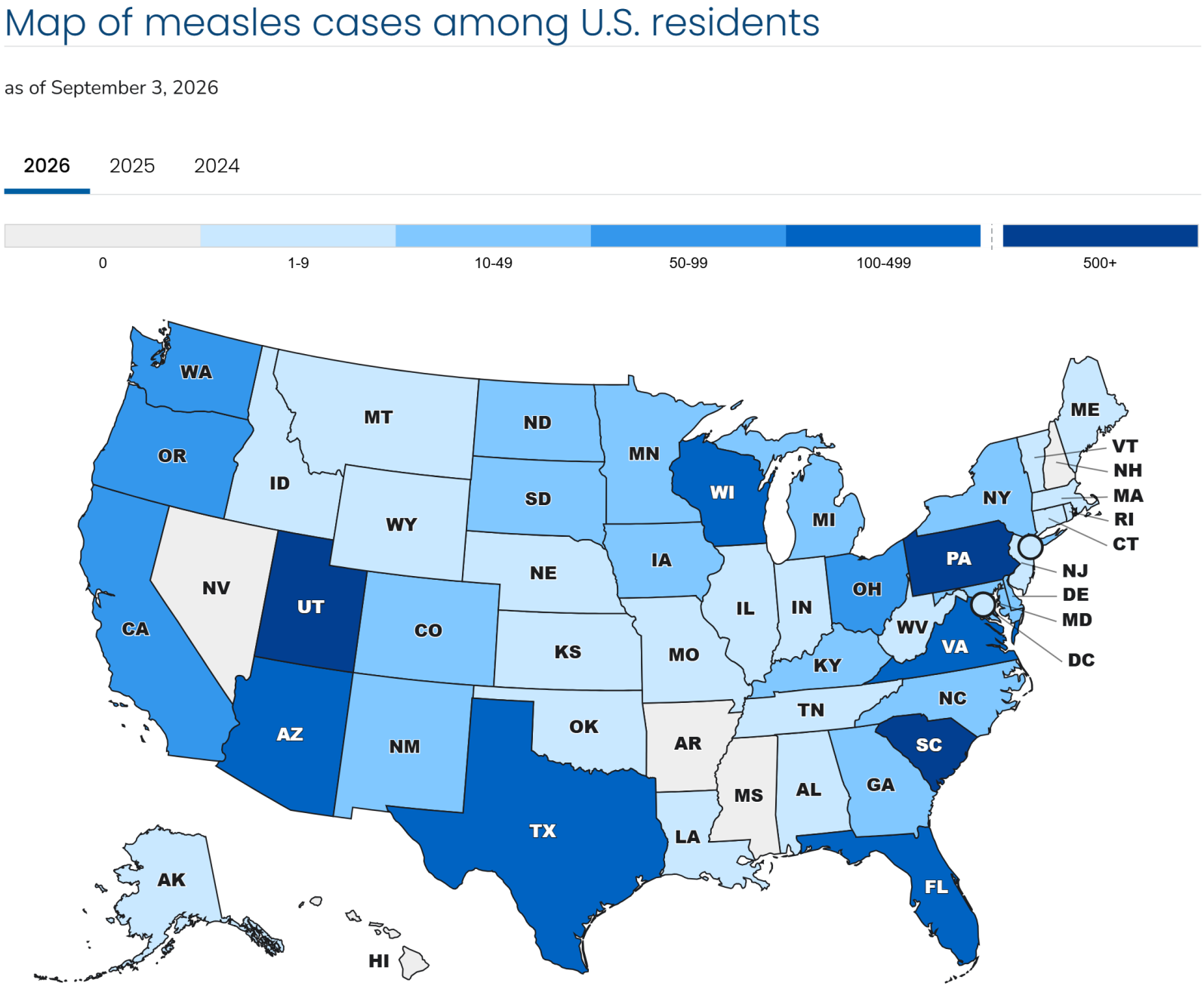
Map of Measles Cases



[CDC Measles Cases and Outbreaks]

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Iowa Measles Case Counts

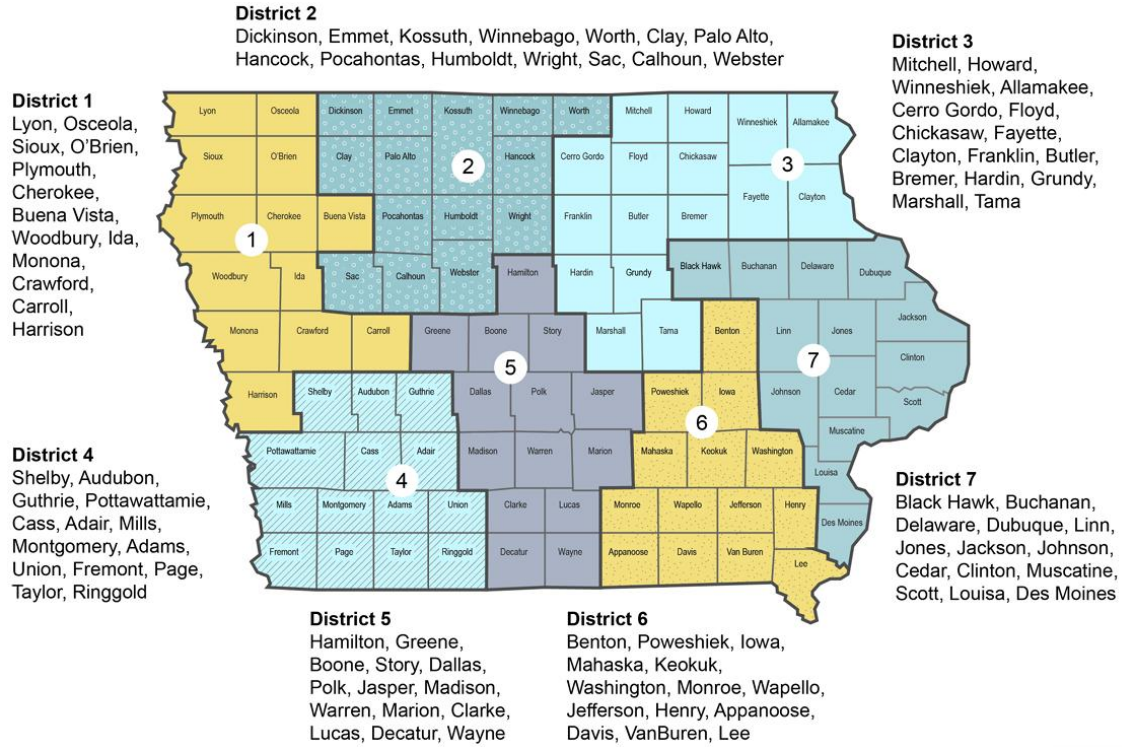
Measles Case Counts: Updated 9/3/2026

Data will be updated weekly on Thursdays

	2026 To Date	2025
Total cases	**22**	**9**
Age		
Under 5 years	3	2
5-19 years	10	2
20+ years	9	5
Vaccination Status		
Unvaccinated or unknown	20	6
Vaccinated (1 or more doses of a measles-containing vaccine ≥14 days before rash onset)	2	3

Iowa HHS Measles

HHS District 3	1
HHS District 4	10
HHS District 5	5
HHS District 6	6

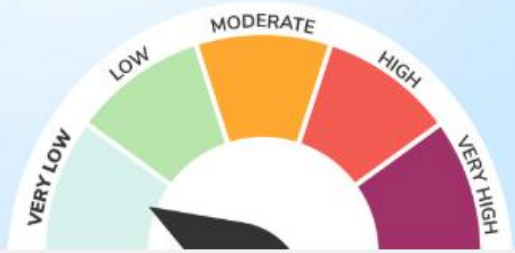


SnapShot for Influenza A, COVID-19 & RSV

Time Period: August 23, 2026 - August 29, 2026

Influenza A

Wastewater viral activity levels for influenza A are **very low**.



COVID-19

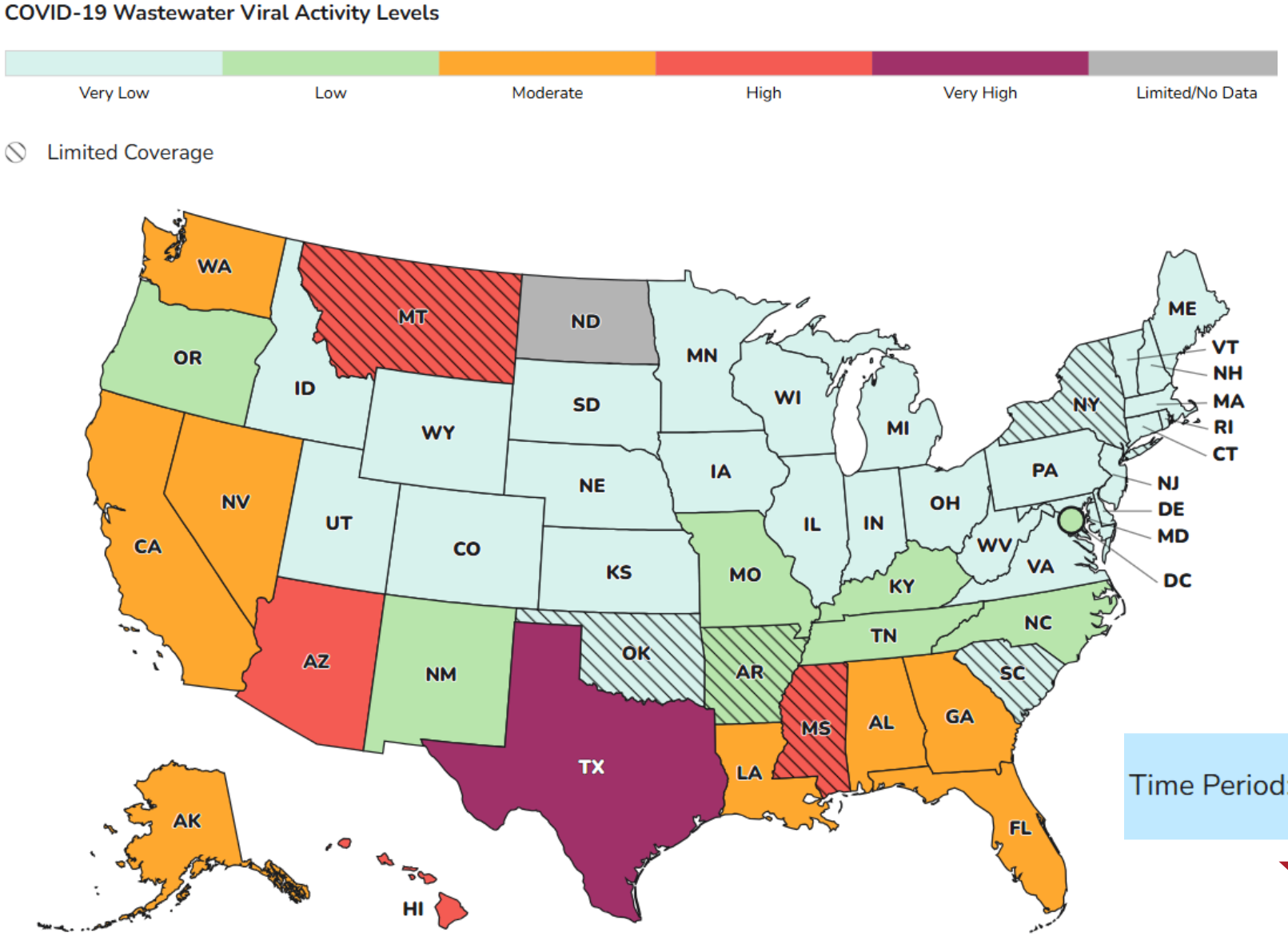
Wastewater viral activity levels for COVID-19 are **very low**.

RSV

Wastewater viral activity levels for RSV are **very low**.

National Wastewater Data for Respiratory Viruses

COVID-19 Wastewater Viral Activity Levels



Time Period: August 23, 2026 - August 29, 2026

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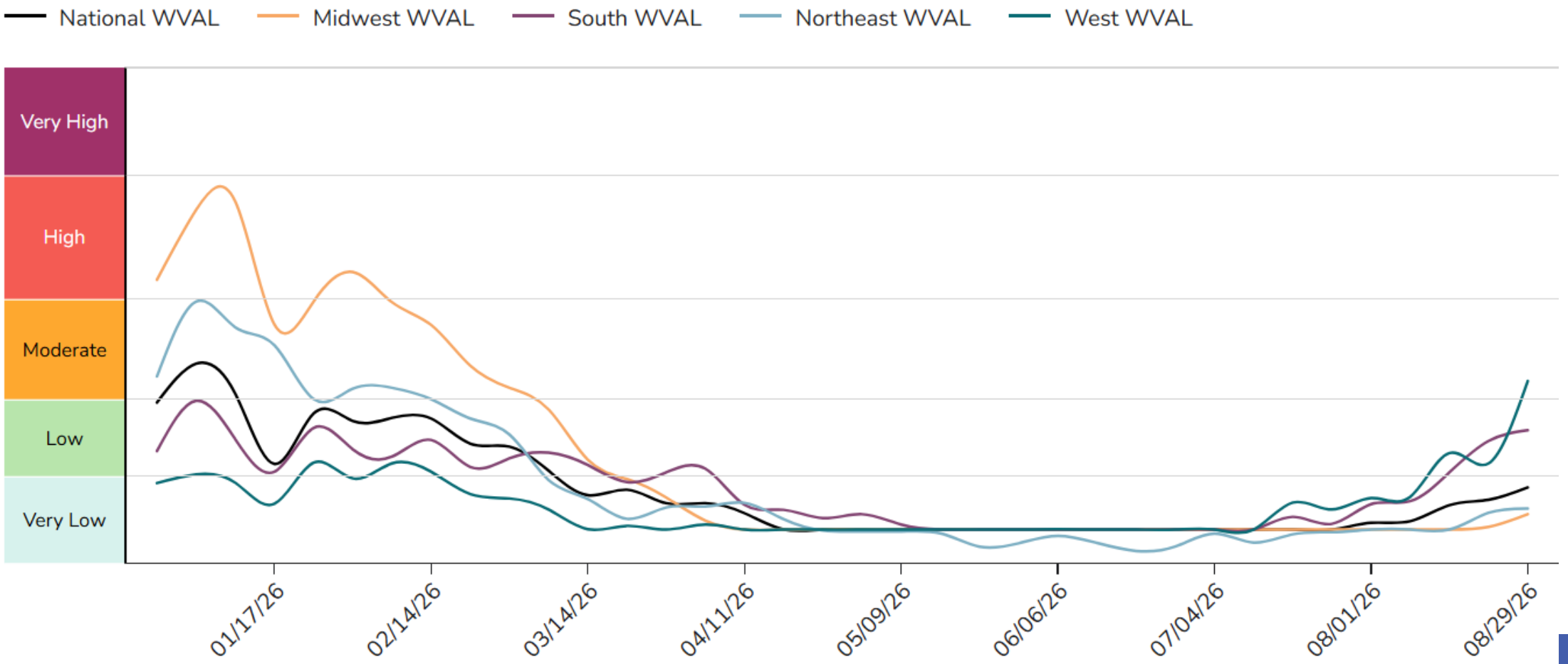
COVID-19 National and Regional Trends



Select Infection Prevention and Control Topics: FAQs and Brief Discussion

Rebecca Martinez, BSN, BA, RN, CIC

Infection Preventionist, NE ICAP

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Learning Objectives

Discuss

Discuss selected IPC topics based on frequently asked questions (FAQs) or identified gaps.

Illustrate

Illustrate how a risk assessment could be performed for a situation or task.

Identify

Identify how disinfectant efficacy is dependent upon proper use and adherence to contact time.

What does it mean to “perform a risk assessment” or make decisions “based on assessment of risk” for a specific situation or task?

- An infection control risk assessment for a specific situation or task evaluates or assesses potential infection risks associated with that task and outlines control measures to mitigate hazards and reduce risk.

Simple SBAR Format for Assessing Risk

SITUATION

- **Situation of Concern**
  - The situation, task, activity, or area of concern

BACKGROUND

- **Background Details**
  - Include background details if this situation was assessed before and any associated outcomes
- **Hazards or Risks Identified**

ASSESSMENT

- **Assess Controls Currently in Place to Reduce Hazards or Risk**
  - Assess remaining risks
  - Assess level of remaining risks (e.g. high, medium, low)

RECOMMEND-ATIONS

- **Recommended or Proposed Controls to Be Implemented to Further Reduce Risk**
  - Specific control measures should be proportional with risk level and implemented on a reasonable timeframe.
- **Document Decisions Made and Specific Recommendations Adopted**

Example Risk Assessment for Primary Disinfectant with 10 Minute Contact Time

SITUATION

- Primary disinfectant has a long contact time of 10 minutes and isn't being met consistently.
- Germs can't be expected to be killed when contact time is not achieved.

BACKGROUND

- Disinfectant was switched by EVS during the COVID-19 pandemic due to supply chain issues.
- Audits consistently show surfaces are not staying wet for 10 minutes, (9 of last 10 audits) and feedback was given.
- EPA allows a max 10 minute contact time but not adhering to contact time can lead to spread of pathogens.

ASSESSMENT

- HCP upon hire are told to keep surfaces wet for 10 minutes and refresher training is given annually.
- HCP report production pressure and need to reapply the disinfectant twice to keep the surface wet.
- Despite education, high risk that surfaces are not being adequately cleaned and disinfected between patients.

RECOMMEND-ATIONS

- Recommended for EVS and IP to explore disinfectants with a shorter contact time (e.g. 5 minutes or ideally less). Characteristics to be documented on a spreadsheet (i.e. contact time, formulation, application, compatibility etc.).
- HCP to have training on new disinfectant and posted flyer to be updated with photo of new disinfectant and contact time.

Document Decisions Made and Specific Recommendations Adopted

NE ICAP Risk Assessment Resources

ICAP
Infection Control Assessment and Promotion Program

Infection Prevention Risk Assessment for High Risk Tasks

Completed by (list all involved): _____ **Date:** _____

Activity / Area of Concern (Existing and Potential) *Identify known and potential hazards for the task.*

Hazards Identified *What can cause harm?* *What harm is possible?* *Persons who could be harmed* *Property which may be damaged*	**Current Risk Value (High, Medium, or Low)** *Consider the severity and the likelihood as though there are no controls.*	**Controls in place to eliminate or reduce the risk** **Include Engineering, Administrative and PPE** *How do the controls compare to 'best practices'?*	**Remaining Risks**	**What controls could further reduce the risk?** *Identify who will take the action, when they will take the action, and make note of when the action is completed.*

Instructions:

- List the existing and potential hazards associated with the task, include both health and safety hazards.
- Keep in mind the different types of hazards. i.e. Chemical, Biological, Physical, Ergonomic, and Psychosocial.
- Complete the risk analysis and determine the overall risk level by assigning the Incident Probability (how likely is it to occur), Incident Severity (how serious would it be) and enter the Risk Level.
- List the current or proposed controls for each hazard identified. The complexity of the controls should be proportional to the overall risk level.
- It is the responsibility of the supervisors to ensure controls are put in place in a reasonable timeframe based on the overall Risk Level.
- Individuals completing the hazard assessment must sign off on the document.
- The document must be kept on file.

Risk Level

- *High Risk* (take immediate action to eliminate the risk or implement appropriate controls to lower the risk)
- *Medium Risk* (take timely action to implement appropriate controls to lower or minimize risk)
- *Low Risk* (continued operation is permissible with minimal controls)

Modified from template by Mariah Gesink, MPH at CHI Health on 6/16/2021

NE ICAP - Template for Infection Prevention Risk Assessment for High Risk Tasks

- NE ICAP Infection Prevention Risk Assessment Webinar 5/25/2022
  - Focuses on facility-wide IPC risk assessments but still applicable towards situational risk assessments.

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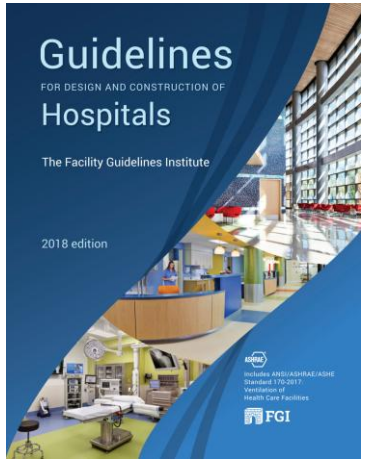
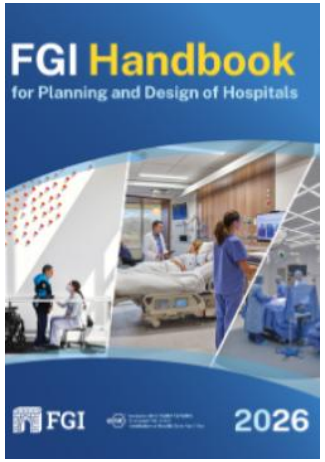
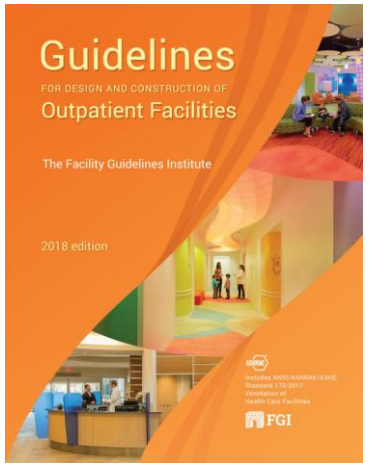
What is the Facility Guidelines Institute (FGI) and why is it important?

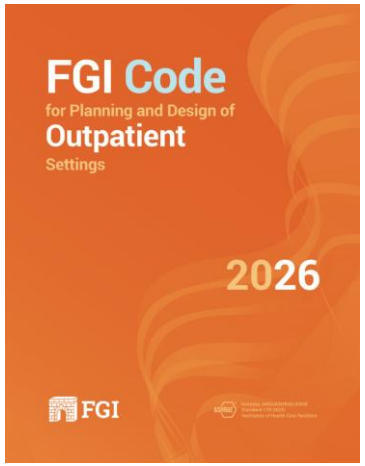
- The FGI Guidelines have been the trusted standard for the planning, design, and construction of health and residential care facilities.

- Beginning with the 2026 edition, that trusted foundation evolves into the FGI Codes for Planning and Design and the FGI Handbooks for Planning and Design.
  - **FGI Codes** establish the minimum requirements that support regulatory compliance and facility safety.
  - **FGI Handbooks** build on that foundation by incorporating the FGI Code alongside expert commentary, technical guidance, and best practices that help health care design professionals understand and apply the requirements with confidence.









FGI Editions

Nebraska Has Adopted FGI Guidelines

Nebraska 2018 Edition

NEBRASKA adopted the 2018 *Guidelines for Design and Construction* documents to be applied to any facility currently licensed under the Nebraska Healthcare Facility Licensure Act or that will be licensed under the act once construction has been completed. Construction means a facility or distinct part of a facility in which services are to be provided which is enlarged, remodeled, or altered in any fashion, or is built from the ground up. Minor projects such as repairing or replacing existing materials do not fall under these requirements. These requirements apply to ambulatory surgery centers, critical access hospitals, general acute hospitals, and other hospitals. For assisted living facilities, long-term care hospitals, nursing facilities, and skilled nursing facilities, the 2018 Guidelines apply to new construction projects only.

Facility Guidelines Institute (FGI)

Nebraska Revised Statute 71-439 Design standards for health care facilities; adoption by Legislature; waiver of rule, regulation, or standard; when; procedure.

Plan Ahead to Reduce Risks Associated with Design, Construction or Renovation

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- Facility planning should include considering designs that reduce risks to patients and staff and facilitate adherence to best infection prevention and control practices.

- Healthcare staff and members of the construction team should be educated about the potential detrimental effects of construction and renovation and ways to secure a safe environment.

Why is an Infection Control Risk Assessment (ICRA) for construction or renovation important?

- An infection-control risk assessment (ICRA) is conducted before initiating repairs, demolition, construction, or renovation activities can identify potential exposures of susceptible patients to dust and moisture and determines the need and extent of dust and moisture containment measures.

- An example of designing an ICRA as a matrix, the policy for performing an ICRA and implementing its results, and a sample permit form that streamlines the communication process are available.

CDC Guidelines for Environmental Infection Control
ASHE ICRA 2.0 Toolkit
NE ICAP Webinar on ICRA 2022.08.24

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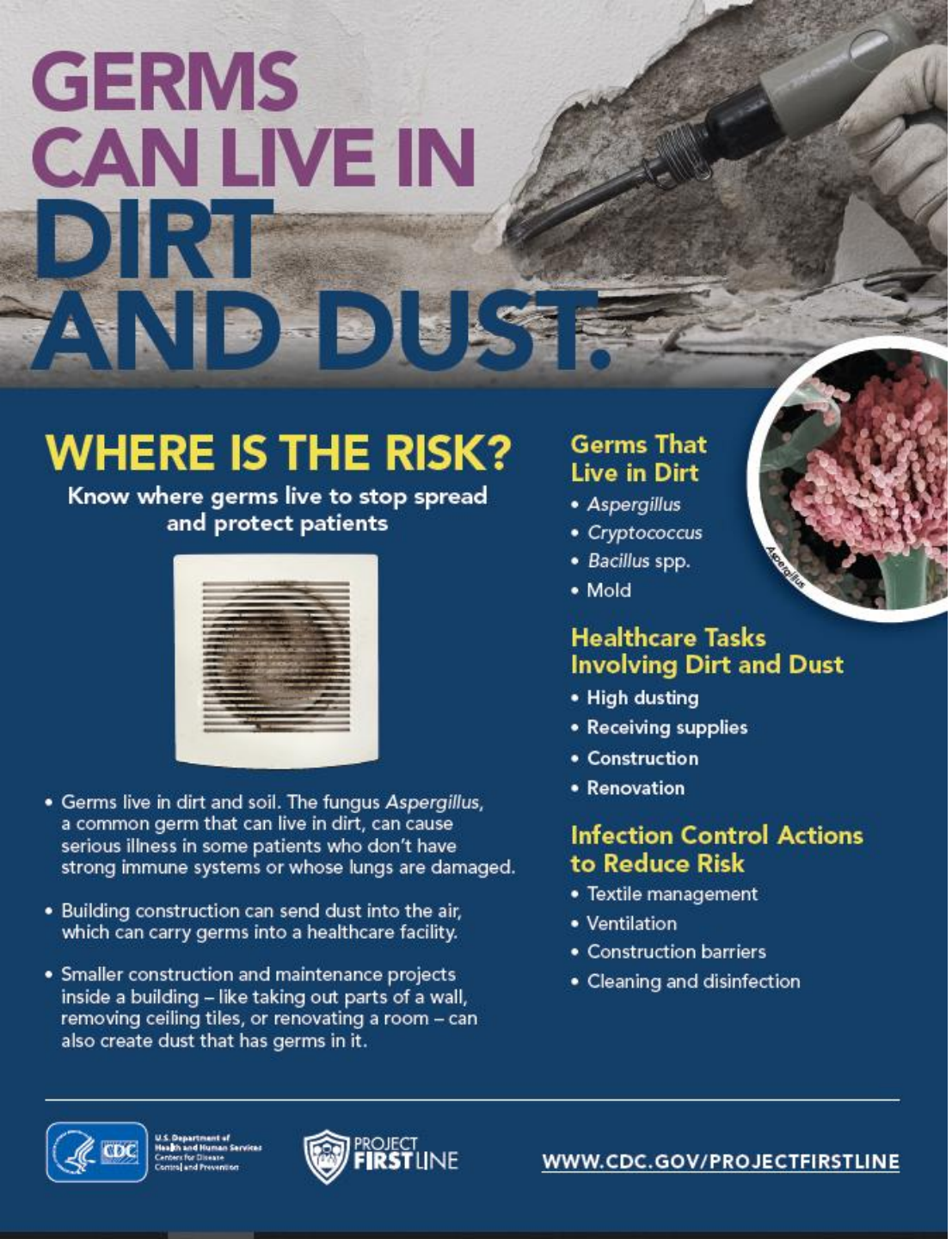

CDC Project Firstline Dirt and Dust Infographic

- Germs live in dirt and soil.
  - Aspergillus, a common germ (fungus) can live in dirt, and can cause serious illness in some patients who don't have strong immune systems or whose lungs are damaged.
  - Building construction can send dust into the air, which can carry germs into a healthcare facility.
  - Smaller construction and maintenance projects inside a building – like taking out parts of a wall, removing ceiling tiles, or renovating a room – can also create dust that has germs in it.
- Take actions to reduce risk including:
  - Implementing construction barriers.
  - Ensuring proper ventilation and air quality.
  - Protecting linen and managing textiles properly.
  - Cleaning and disinfecting.

CDC Project Firstline Dirt and Dust

What does it mean to be an EPA registered hospital disinfectant?

Limited

- Effective against only a specific major group of microorganisms (such as gram-positive [e.g., *Staphylococcus aureus*] **or** gram-negative [e.g., *Salmonella enterica*] bacteria).

General or Broad Spectrum

- Effective against both gram-positive **and** gram-negative bacteria *(Staphylococcus aureus and Salmonella enterica).*
- Typically used in residential, commercial, institutional, and other sites

Hospital

- Is a general or broad-spectrum disinfectant **and also** is effective against the nosocomial bacterial pathogen Pseudomonas aeruginosa.
- Used in hospitals, clinics, dental offices, or other health care facilities.

EPA - Antimicrobial Pesticides

Selected EPA-Registered Disinfectants

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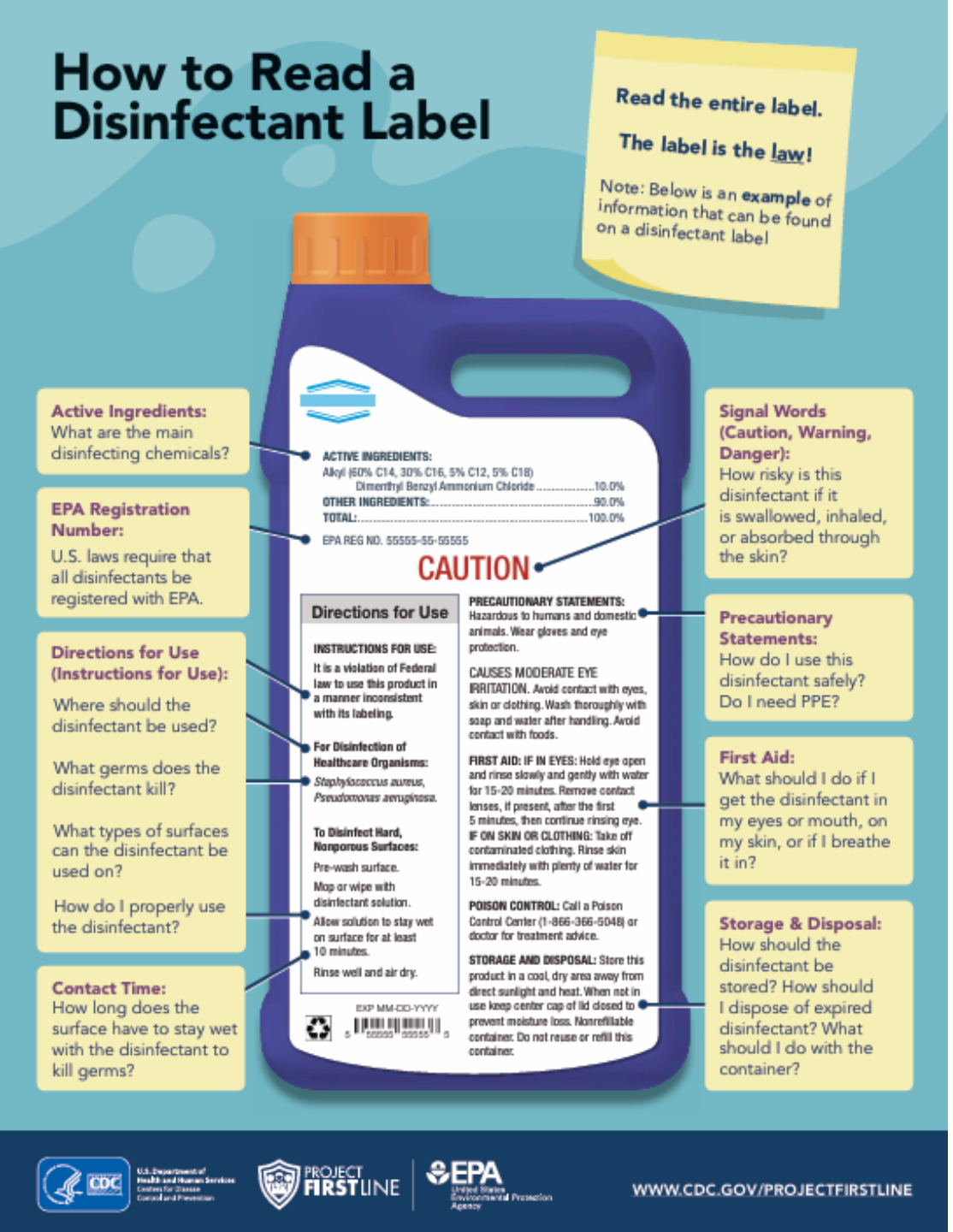

How to Read a Disinfectant Label

- On the disinfectant label it should have:
  - Active ingredients
  - EPA registration number
  - Instructions for use (IFU)
  - Contact time
    - This is how long the surface has to stay wet with the disinfectant to kill germs.
  - Precautions and hazard warnings
  - First aid
  - Storage & Disposal

CDC Project Firstline - How to Read a Disinfectant Label

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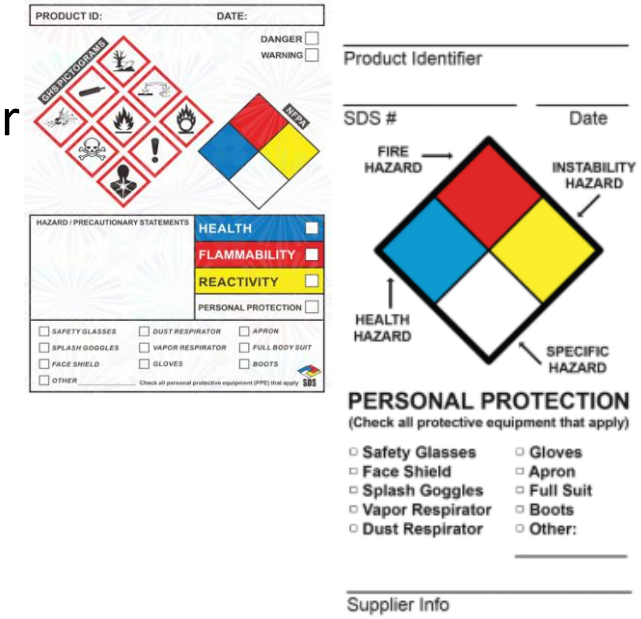
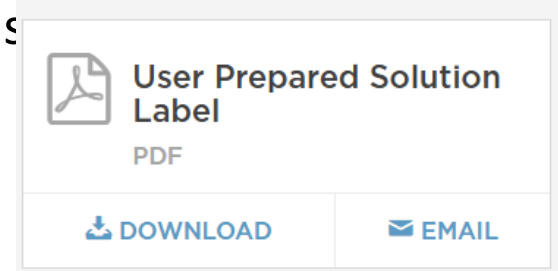
How do secondary containers need to be labeled and why?

- Properly label secondary containers used to store disinfectant when not in immediate use.
  - Per OSHA, “Immediate use means that the hazardous chemical will be under the control of and used only by the person who transfers it from a labeled container and used only within the work shift in which it is transferred.
  - Secondary containers should be labeled with a product identifier that provides knowledge of what is in a container and includes at least general information of the chemical’s hazards and safety precautions.
    - Ready to use labels or wipeable stickers are generally available through the manufacturer or are available for purchase.
  - Contents should be labeled with a beyond use date based on manufacturer's instructions for stability if not in immediate use.

Examples for Illustration Only





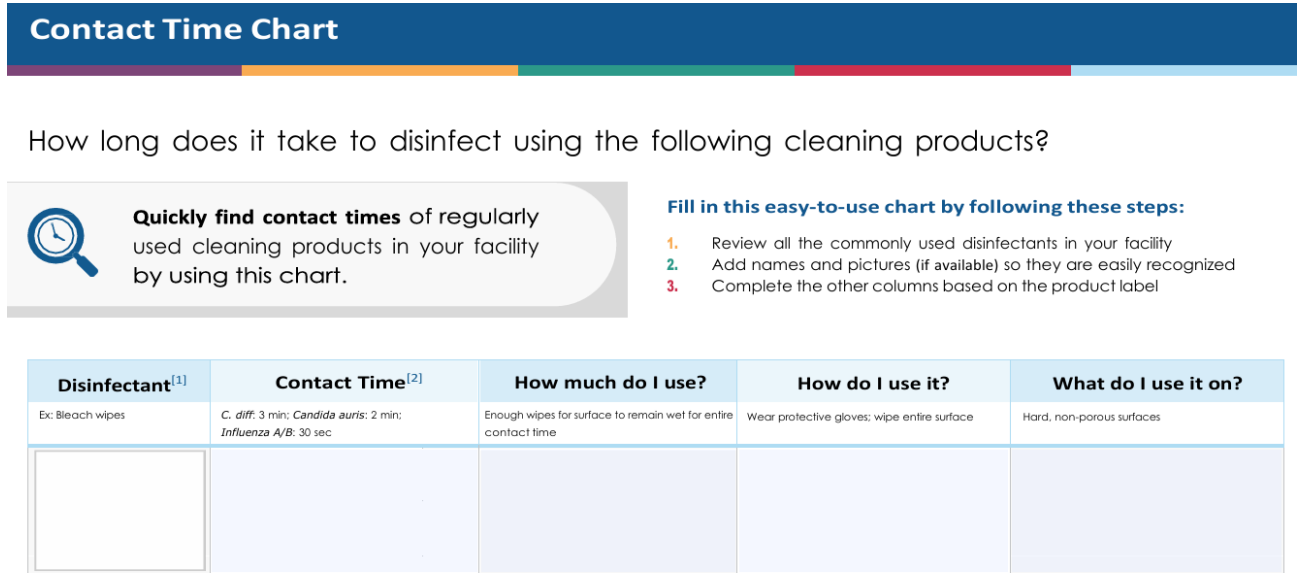
[OSHA Standard 1910.1200 - Hazard Communication]

[OSHA Letters of Interpretation - Labeling of Secondary Containers]

[CDC - Environmental Cleaning Best Practices PDF]

What contact time should be followed when multiple times are listed?

- Follow the stated contact time from the disinfectant label / IFU.
  - For further information, consult the manufacturer's technical data.
    - Remember that the contact time being used should never be less than the time it takes to kill the 3 bacteria for an EPA registered hospital disinfectant *(Staphylococcus aureus, Salmonella enterica, and Pseudomonas aeruginosa).*
      - When efficacy against a certain organism is needed (e.g. *C. difficile or C. auris*) then ensure staff are aware of any different contact times and adhere to those times.
- Consider using a chart to document and review contact times and uses for the disinfectants in your facility.



Contact Time Chart

How long does it take to disinfect using the following cleaning products?

Quickly find contact times of regularly used cleaning products in your facility by using this chart.

Fill in this easy-to-use chart by following these steps:

1. Review all the commonly used disinfectants in your facility
2. Add names and pictures (if available) so they are easily recognized
3. Complete the other columns based on the product label

Disinfectant[1]	Contact Time[2]	How much do I use?	How do I use it?	What do I use it on?
Ex: Bleach wipes	*C. diff*: 3 min; *Candida auris*: 2 min; *Influenza A/B*: 30 sec	Enough wipes for surface to remain wet for entire contact time	Wear protective gloves; wipe entire surface	Hard, non-porous surfaces

[CDC Project Firstline Washington DOH Contact Time Chart Template]

Should there be a separate “enteric” precautions sign?

- Facilities can always make their own signs.
- CDC has 3 main categories of transmission-based precautions: contact, droplet, and airborne with links to optional signage.
  - Various CDC guidance for *C. difficile* includes preference for hand washing and to use an EPA approved spore killing disinfectant.

Example for Illustration Only

CDC Guideline for Isolation Precautions

CDC Transmission-Based Precautions

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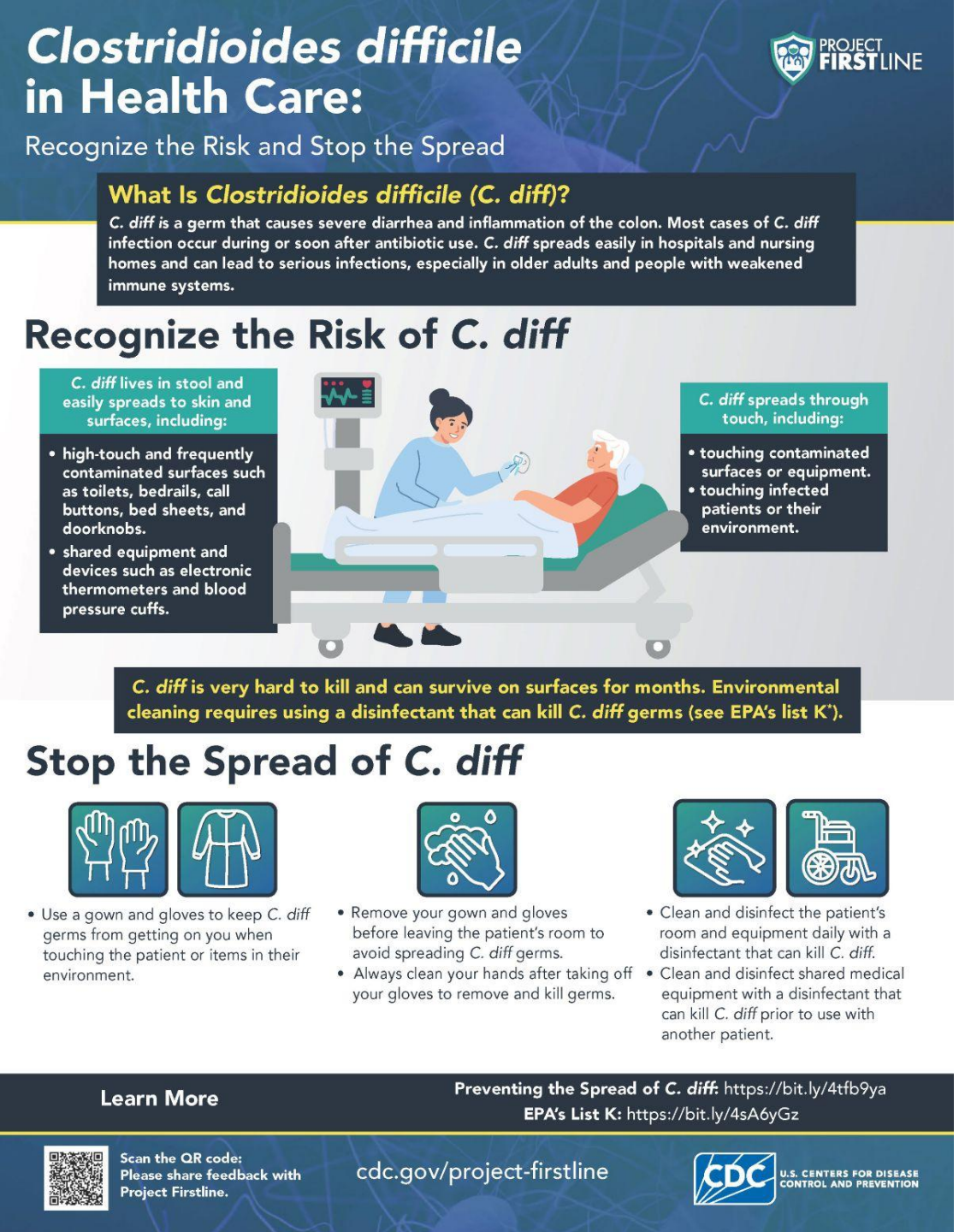

CDC Project Firstline Resource: *C. difficile*

- *Clostridioides difficile (C. diff)* is a germ that causes severe diarrhea and inflammation of the colon.
- The bacteria lives in the stool and spreads easily through touch to other people and surfaces.
- Stop the spread of C. diff by:
  - Using a gown and gloves when touching the patient or their environment.
  - Remove the gown and gloves before leaving the room.
  - Clean hands after gloves removal; washing hands removes germs.
  - Clean and disinfect the patient's room and any equipment with a disinfectant that kills C. diff (see EPA's list K).

CDC Project Firstline C. diff

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Where can I find general guidance for healthcare settings regarding a TB plan, screening and testing?

- The NE Tuberculosis (TB) Program does not have official state specific guidance and recommends following CDC guidance. The below two references are key and are applicable for all healthcare settings; such as inpatient, outpatient, and long-term care (LTC) settings.
  - **CDC - Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings 2005**
    - Inpatient Settings section starts on page 20.
    - Outpatient Settings section starts on page 24.
    - Long-Term-Care Facilities section starts on page 27.
  - **CDC – MMWR - Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019**
- Kristin Bertrang, TB Program Manager for the State of Nebraska, is an excellent resource for questions about TB in Nebraska and can be contacted at 402-471-6441 or email Kristin.Bertrang@nebraska.gov
  - Decisions related to the facility's TB plan should start by determining local risk of TB, the facility can reach out to their local health department or contact Kristin.
  - Kristin discussed HCP TB screening, testing, and treatment on the 8/13/25 NE ICAP webinar.

What are TB screening recommendations for HCP in a healthcare setting?

There is no formal statute in Nebraska related to healthcare personnel (HCP) TB screening, though the expectation is to follow current CDC recommendations. The below is a summary of baseline (upon hire) and annual recommendations.

BASELINE (upon hire)

- Perform baseline screening upon hire of HCP consisting of three components:
  - An individual risk assessment
  - Symptom evaluation
  - Testing with either a two-step tuberculin skin test (TST) or IGRA blood test.

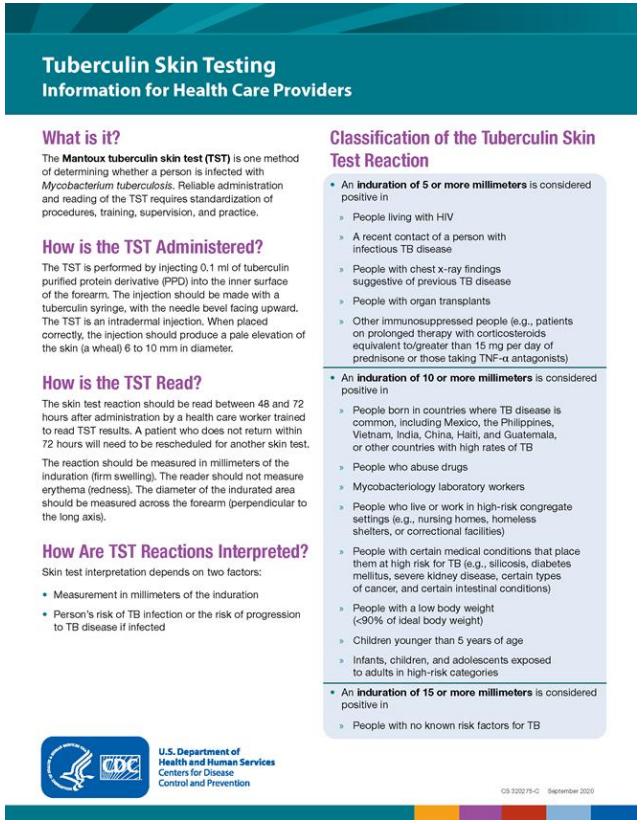
ANNUAL (yearly)

- Annual TB testing is no longer routinely recommended unless there is ongoing risk in the facility.
- HCP with untreated latent TB infection (LTBI) should receive an annual TB symptom screening to detect early evidence of TB disease and to reevaluate the risk and benefits of recommended treatment for LTBI.

CDC – MMWR - Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019

What resources are available to help train HCP on TB Skin Testing?

- CDC has free training materials within their Mantoux Tuberculin Skin Test Toolkit to download which includes a fact sheet, wall chart, and video.



Tuberculin Skin Testing
Information for Health Care Providers

What is it?

The **Mantoux tuberculin skin test (TST)** is one method of determining whether a person is infected with *Mycobacterium tuberculosis*. Reliable administration and reading of the TST requires standardization of procedures, training, supervision, and practice.

How is the TST Administered?

The TST is performed by injecting 0.1 ml of tuberculin purified protein derivative (PPD) into the inner surface of the forearm. The injection should be made with a tuberculin syringe, with the needle bevel facing upward. The TST is an intradermal injection. When placed correctly, the injection should produce a pale elevation of the skin (a wheal) 6 to 10 mm in diameter.

How is the TST Read?

The skin test reaction should be read between 48 and 72 hours after administration by a health care worker trained to read TST results. A patient who does not return within 72 hours will need to be rescheduled for another skin test.

The reaction should be measured in millimeters of the induration (firm swelling). The reader should not measure erythema (redness). The diameter of the indurated area should be measured across the forearm (perpendicular to the long axis).

How Are TST Reactions Interpreted?

Skin test interpretation depends on two factors:

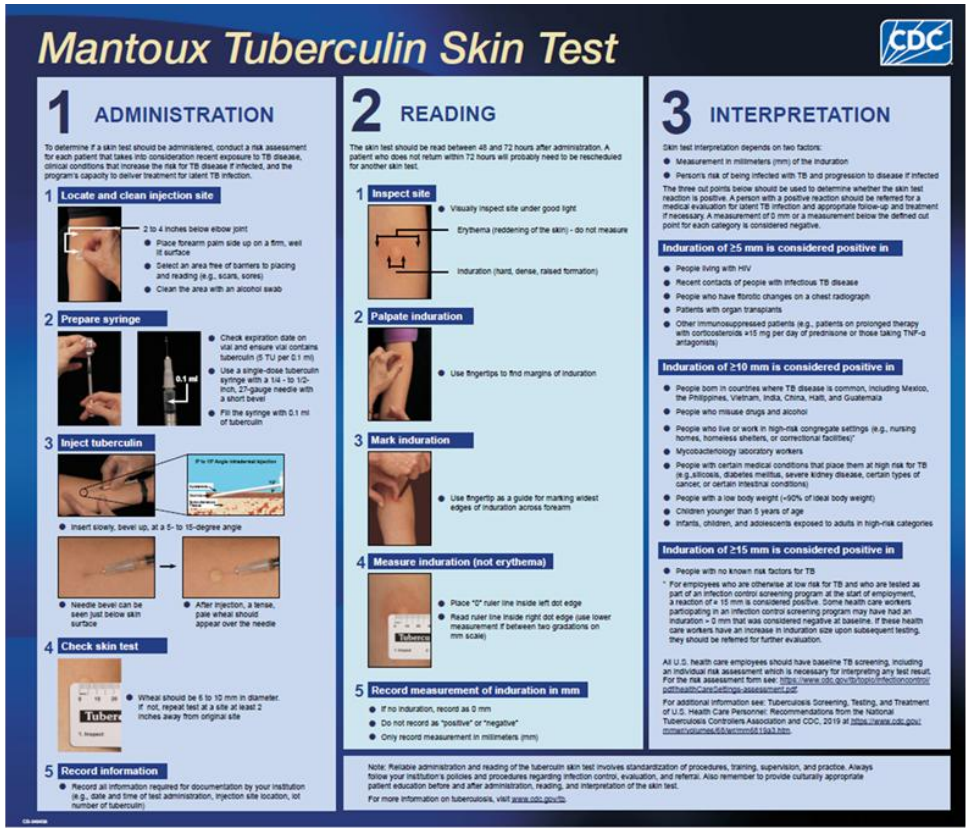
- Measurement in millimeters of the induration
- Person's risk of TB infection or the risk of progression to TB disease if infected

Classification of the Tuberculin Skin Test Reaction

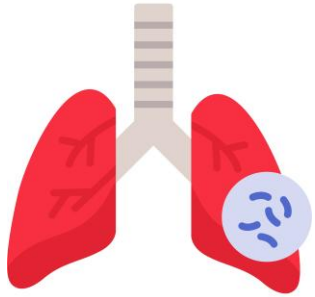
- An **induration of 5 or more millimeters** is considered positive in
  - People living with HIV
  - A recent contact of a person with infectious TB disease
  - People with chest x-ray findings suggestive of previous TB disease
  - People with organ transplants
  - Other immunosuppressed people (e.g., patients on prolonged therapy with corticosteroids equivalent to/greater than 15 mg per day of prednisone or those taking TNF-α antagonists)
- An **induration of 10 or more millimeters** is considered positive in
  - People born in countries where TB disease is common, including Mexico, the Philippines, Vietnam, India, China, Haiti, and Guatemala, or other countries with high rates of TB
  - People who abuse drugs
  - Mycobacteriology laboratory workers
  - People who live or work in high-risk congregate settings (e.g., nursing homes, homeless shelters, or correctional facilities)
  - People with certain medical conditions that place them at high risk for TB (e.g., silicosis, diabetes mellitus, severe kidney disease, certain types of cancer, and certain intestinal conditions)
  - People with a low body weight (<90% of ideal body weight)
  - Children younger than 5 years of age
  - Infants, children, and adolescents exposed to adults in high-risk categories
- An **induration of 15 or more millimeters** is considered positive in
  - People with no known risk factors for TB

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

CS 320275-G September 2020



Can a single tuberculin skin test be administered upon hire for HCP without a recent TST?



- Current recommendations are to perform a 2-step TST upon hire if a prior TST was not performed recently (within past 12 months). Alternately, a blood test (IGRA) could be performed in a single step.
  - Two-step testing is recommended for the initial TB skin test for adults who may be tested periodically, such as health care personnel. This procedure is especially important for settings that are classified as low-risk where testing is indicated only upon exposure. Some people with latent TB infection have a negative reaction to the TB skin test when tested years after being infected. However, if they are tested again within a year of the first test, they may have a positive reaction. The first TB skin test can "trigger the memory" of the immune system, boosting its ability to react to the second TB skin test.

CDC - Baseline Tuberculosis Screening and Testing for Health Care Personnel

CDC - Clinical Testing Guidance for Tuberculosis: Tuberculin Skin Test

CDC – MMWR - Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019

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What kind of PPE is needed for laundry?

Gown	• Use gowns for any sorting, rinsing, or if work control practices are insufficient to ensure contaminated laundry does not touch the uniform or exposed skin of the laundry personnel.
Eye Protection	• Use eye protection for any splash risk such as with manual pre-washing and chemical splash risks.
Gloves	• Use gloves for handling soiled laundry. • Consider an extended cuff glove option when needing to manually pre-wash to prevent water intrusion.

OSHA - 29 CFR 1910.1030 - BBP

CDC - Guidelines for Environmental Infection Control in Health-Care Facilities (2003) - Background G. Laundry and Bedding

CDC - Environmental Cleaning Best Practices PDF

NE ICAP

What kind of gloves and other PPE should be used for decontaminating instruments and endoscopes?

- Ensure PPE needed for decontamination is easily accessible and visible which includes:
  - Fluid resistant shoe or boot covers if there is potential for shoes becoming contaminated and/or soaked with blood or other body fluids
  - Fluid resistant gown
  - Fluid resistant mask
  - Face and eye protection which could be a combination such as a surgical mask with attached eye shield or face shield
  - Extended cuff puncture resistant gloves to protect from contaminated water and sharps injury

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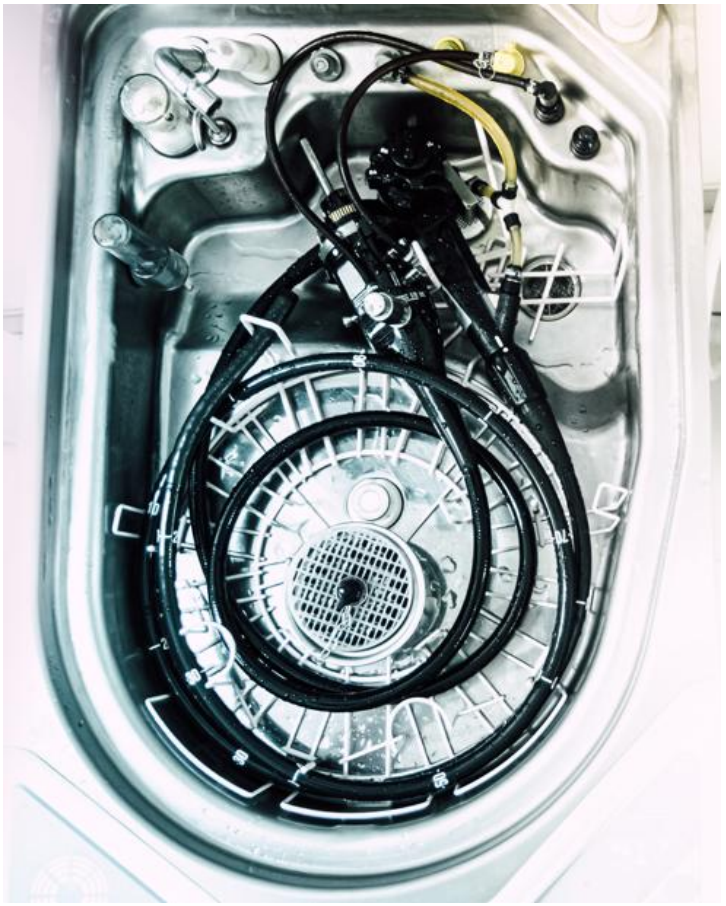
CDC - Guideline for Disinfection and Sterilization in Healthcare Facilities (2008) - Update: June 2024

ANSI/AAMI ST79:2017 Comprehensive guide to steam sterilization and sterility assurance in health care facilities – American National Standard

AORN Guideline for Care and Cleaning of Surgical Instruments (2025)

Do you still need to manual clean the endoscope if there is an automated endoscope reprocessor?

- Some automated endoscope reprocessors (AERs) have cleaning cycles that are validated and cleared by FDA to replace certain manual cleaning steps. Most AER automated cleaning cycles are not intended to replace manual cleaning but are intended to supplement manual cleaning.
  - ANSI/AAMI ST91 and AORN similarly state that **automated cleaning should be a supplement to manual cleaning** and to convene a multi-disciplinary team to conduct a risk assessment to determine whether an AER with an FDA-cleared cleaning cycle may replace manual cleaning of flexible endoscopes excluding duodenoscopes or scopes with an elevator mechanism due to higher risk.
    - NE ICAP supports the above recommendations.



AORN – Guideline for Processing Flexible Endoscopes (9/15/2022)
ASGE - Multisociety Guideline Endoscopes
CDC - Guideline for Disinfection and Sterilization in Healthcare Facilities (2008) - Update: June 2024
ANSI/AAMI ST91:2021 Flexible and semi-rigid endoscope processing in health care facilities

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Why is drying the exterior of the endoscope important?

Before HLD

- The exterior surface of the endoscope should be wiped with a clean non-linting cloth (a.k.a. roughly dried) prior to high-level disinfection (HLD).
  - This can aide in visual inspection of the endoscope prior to HLD.
  - This can help to reduce any excessive water that may drip and potentially contaminate surfaces prior to HLD.

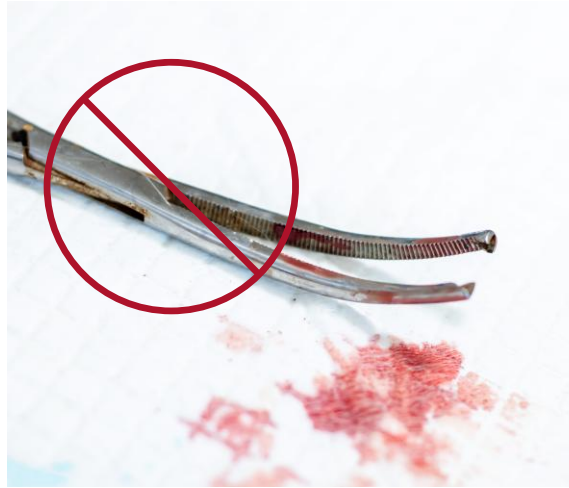
After HLD

- After HLD, the exterior of the endoscope should be completely dried using clean gloves and a clean, lint-free cloth.
  - This aides in scope drying to reduce a potential reservoir for pathogens.
  - This reduces the risk of spreading water droplets to other surfaces or other scopes in the drying cabinet.

AORN – Guideline for Processing Flexible Endoscopes (9/15/2022)
ASGE - Multisociety Guideline Endoscopes
CDC - Guideline for Disinfection and Sterilization in Healthcare Facilities (2008) - Update: June 2024
ANSI/AAMI ST91:2021 Flexible and semi-rigid endoscope processing in health care facilities

Why is point of use treatment (pre-cleaning) so important?

- Keeping instruments moist helps prevent soil (e.g., blood, body fluids) from drying and adhering to the instruments. Dried soil can make instruments more difficult to clean and potentially lead to the formation of dry-surface biofilm.
- Recommend having a basin of sterile water for wiping away gross soil during surgeries.
  - Do not use saline because it is damaging to instrument surfaces and can cause corrosion, rusting, and pitting.
- Recommend to make available and use POU treatment for all instruments prior to decontamination.
  - AORN guidelines state to "Keep instruments moist until they are cleaned by using either saturation with an enzymatic pretreatment product or a towel moistened with water placed over the instruments. Do not use saline".



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CDC - Guideline for Disinfection and Sterilization in Healthcare Facilities (2008) - Update: June 2024

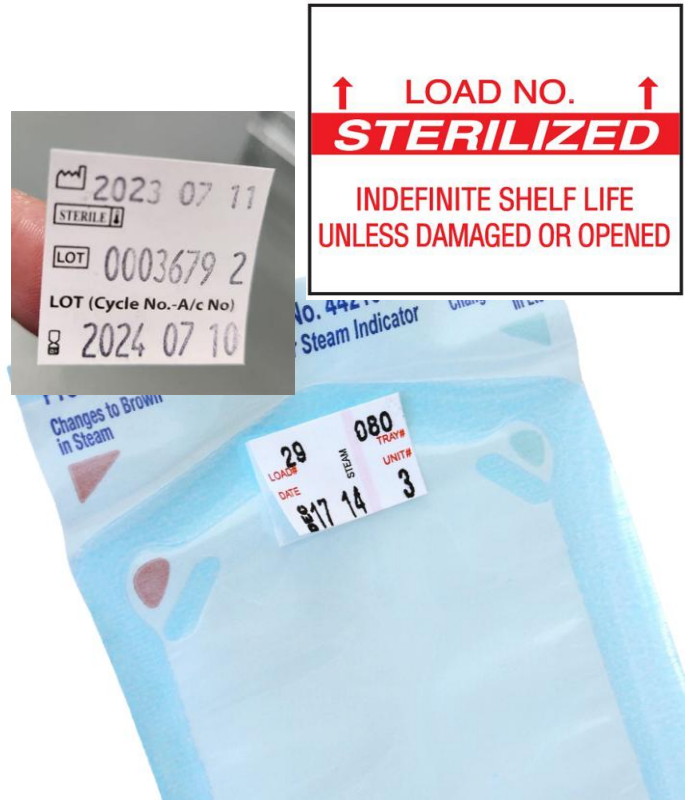
ANSI/AAMI ST79:2017 Comprehensive guide to steam sterilization and sterility assurance in health care facilities – American National Standard

AORN Guideline for Care and Cleaning of Surgical Instruments (2025)

Why do sterile packs need to be labeled with an identified load number?

- CDC and ANSI/AAMI ST79 recommends to label sterilized items with a lot control identifier / number that indicates:
  - the sterilizer used,
  - the cycle number,
  - contents,
  - the date of sterilization,
  - and, if applicable, the expiration date.

- Labeling should be on the non-porous side of the pouch.



Examples for Illustration Only

CDC - Guideline for Disinfection and Sterilization in Healthcare Facilities (2008) - Update: June 2024

ANSI/AAMI ST79:2017 Comprehensive guide to steam sterilization and sterility assurance in health care facilities – American National Standard

AORN – Guideline for Sterilization (10/17/2024)

What are the 2026 – 2027 Influenza Vaccines?

- CDC has posted Interim Clinical Considerations for the Use of Seasonal Influenza Vaccines in the United States as guidance for public health and healthcare professionals for the 2026-2027 flu season.
  - The seasonal influenza vaccines are trivalent, containing components of three different influenza viruses: an influenza A(H1N1)pdm09 virus, an influenza A(H3N2) virus, and an influenza B/Victoria virus.
    - All three virus components of the 2026-2027 U.S. season were updated.
  - Most of the vaccine is provided within pre-filled syringes (PFS) with a multi-dose vial (MDV) option and a pre-filled single-use intranasal sprayer option.

CDC's Table of 2026 -2027 Influenza Vaccines

Vaccine type and trade name (manufacturer)	Presentation	Age indication	μg HA (IIV3s and RIV3) or virus count (LAIV3) for each vaccine virus (per dose)	Route
IIV3s (standard-dose, egg-based vaccines[†])				
FLUARIX (GlaxoSmithKline)	0.5-mL PFS	≥6 mos	15 μg/0.5 mL	IM[§]
FLULAVAL (GlaxoSmithKline)	0.5-mL PFS	≥6 mos	15 μg/0.5 mL	IM[§]
Fluzone (Sanofi)	0.5-mL PFS[¶]	≥6 mos[¶]	15 μg/0.5 mL	IM[§]
	5.0-mL MDV	≥6 mos[¶]	7.5 μg/0.25 mL 15 μg/0.5 mL	IM[§]
ccIIV3 (standard-dose, cell culture–based vaccine)				
FLUCELVAX (Seqirus)	0.5-mL PFS	≥6 mos	15 μg/0.5 mL	IM[§]
HD-IIV3 (high-dose, egg-based vaccine[†])				
Fluzone High-Dose (Sanofi)	0.5-mL PFS	≥65 yrs	60 μg/0.5 mL	IM[§]
aIIV3 (standard-dose, egg-based vaccine[†] with MF59 adjuvant)				
FLUAD (Seqirus)	0.5-mL PFS	≥65 yrs	15 μg/0.5 mL	IM[§]
RIV3 (recombinant HA vaccine)				
Flublok (Sanofi)	0.5-mL PFS	≥9 yrs	45 μg/0.5 mL	IM[§]
LAIV3 (egg-based vaccine[†])				
FluMist (AstraZeneca)[**]	0.2-mL prefilled single-use intranasal sprayer	2 through 49 yrs	$10^{6.5–7.5}$ FFU/0.2 mL	Intranasal

CDC Table 1 of Seasonal Influenza Vaccines in the United States with Footnotes and Details

Where can I find guidance and resources for help promote vaccination?

Immunize.org

- Immunize.org supports healthcare professionals with various educational resources and guidance

Infectious Diseases Society of America (IDSA)

- IDSA 2026 Guidelines on the Use of Vaccines for the Prevention of Seasonal COVID-19, Influenza, and RSV Infections in Immunocompromised Patients

American Academy of Family Physicians (AAFP)

- AAFP Announces Fall Immunization Recommendations to Protect Patients and Communities
- AAFP Immunization and Vaccine Schedules and Resources

American Academy of Pediatrics (AAP)

- AAP Respiratory Virus Immunization Guidance for 2026-27
- AAP Recommended Immunization Schedule for Ages 18 Years and Younger (Updated 9/2/2026)

American College of Obstetricians and Gynecologists (ACOG)

- ACOG 2026 Maternal Immunization Schedule

What are 2026-2027 COVID Vaccines?

Manufacturer	Vaccine	FDA Approved Indication	Adult Dosing
Moderna	SPIKEVAX (mRNA)	65 years of age or older, or 6 mos. through 64 yrs with at least 1 high-risk conditions	Available in a pre-filled syringe formulation. Single dose, 0.5 mL If previously vaccinated, administer >2 months after the last dose of COVID-19 vaccine.
	MNEXSPIKE (mRNA)	**Previously vaccinated with any COVID-19 vaccine and:** 65 years of age or older, or 12 years through 64 yrs with at least 1 high-risk conditions	Available in a pre-filled syringe formulation. Single dose, 0.2 mL If previously vaccinated, administer >3 months after the last dose of COVID-19 vaccine.
Pfizer-BioNTech	COMIRNATY (mRNA)	65 years of age or older, or 5 years through 64 years with at least 1 high-risk condition	Available in single dose vials and pre-filled syringe formulation. Single dose, 0.3 mL If previously vaccinated, administer >2 months after the last dose of COVID-19 vaccine.
Novavax	NUVAXOVID (Protein-based vaccine)	65 years of age or older, or 12 yrs through 64 yrs with at least 1 high-risk conditions	Available in a pre-filled syringe formulation. Single dose, 0.5 mL If previously vaccinated, administer >2 months after the last dose of COVID-19 vaccine.

FDA - COVID-19 Vaccines (2026-2027 Formula) for Use in the United States Beginning in Fall 2026

Where are the current main guidelines related to bloodborne pathogen exposure testing, follow-up and treatment?

HIV

- Kofman AD, Struble KA, Heneine W, et al. 2025 US Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Post-exposure Prophylaxis in Healthcare Settings. Infection Control & Hospital Epidemiology. 2025;46(9):863-873. doi:10.1017/ice.2025.10254

Hepatitis B

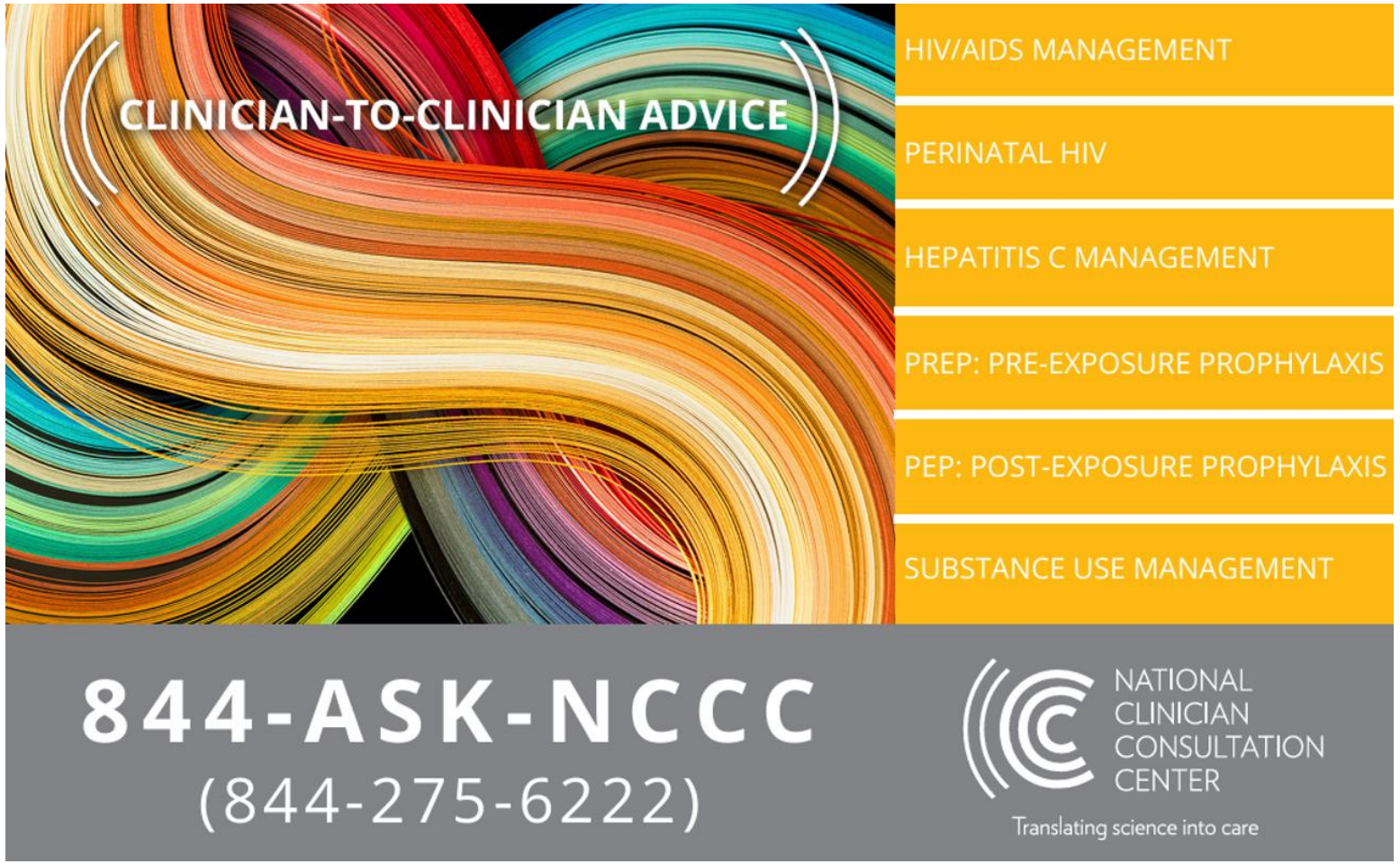
- Fitzgerald B, Kenzie W, Rasmussen S, et al. Morbidity and Mortality Weekly Report Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices Recommendations and Reports Centers for Disease Control and Prevention MMWR Editorial and Production Staff (Serials) MMWR Editorial Board. 2018. https://www.cdc.gov/mmwr/volumes/67/rr/pdfs/rr6701-H.PDF

Hepatitis C

- Moorman AC, de Perio MA, Goldschmidt R, et al. Testing and Clinical Management of Health Care Personnel Potentially Exposed to Hepatitis C Virus — CDC Guidance, United States, 2020. MMWR Recomm Rep 2020;69(No. RR-6):1–8. DOI: http://dx.doi.org/10.15585/mmwr.rr6906a1

What is the National Clinician Consultation Center (NCCC)?

- NCCC supports healthcare providers by providing free and confidential expert consultation.
  - NCCC is funded through grants and partnerships with a number of federal and state agencies including the Centers for Disease Control and Prevention (CDC).
    - NCCC does not accept funding from pharmaceutical or medical device organizations.



Flyer of NCCC Services

NCCC Single Phone Number & PEP Resources

- Call NCCC at **844-ASK-NCCC or 844-275-6222** for all consultations including PEP guidance.
  - A chatbot is available for after hours help.

Call for a Phone Consultation:

844-ASK-NCCC or 844-275-6222
Monday through Friday, 7 a.m. to 5 p.m. PT, excluding holidays
Saturday and Sunday, 10 a.m. to 2 p.m. PT, excluding holidays

- The NCCC PEP Quick Guide for Bloodborne Pathogen Exposures page provides the most up-to-date, user-friendly recommendations for post-exposure prophylaxis and could be referenced in facility policy.

https://nccc.ucsf.edu/clinician-consultation/pep-post-exposure-prophylaxis/
https://nccc.ucsf.edu/clinical-resources/pep-resources/pep-quick-guide-for-exposures/

Questions & Answer Session

- Please use the Q&A box in the webinar platform to type your question so it can be read aloud.
- If your question is not answered during the webinar or you need one-on-one help, call 402.552.2881 Monday to Friday, 8 a.m. to 4 p.m. CST, to speak with an Infection Preventionist.
- You can also email your question to nebraskaicap@nebraskamed.com

Slides & Webinar Recordings

- During the webinar: You can access the slides on the NE ICAP Hospital webpage
- After the webinar: The slides and the recording will be available under the Webinars tab on the Past Webinars and Slides page

Upcoming Opportunities & Education

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

NE ICAP

Survey to Assess Practices to Reduce or Prevent SSIs Related to Knee and Hip Replacement

- The Surgical Site Infection (SSI) Prevention Subcommittee of the Nebraska DHHS Healthcare-Associated Infections and Antimicrobial Resistance (HAI/AR) Program's Advisory Council is focused on efforts to **reduce SSIs associated with knee and hip replacement surgeries.**

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- To better understand current practices, the Subcommittee developed a survey to assess strategies used to prevent infections following primary knee or hip replacement surgery.
- This survey is intended to be completed collaboratively, with one submission requested for each facility.
- Participation is strictly voluntary. Results will be shared with the Advisory Council, participating facilities, and other stakeholders only in de-identified manner. The primary goal is to use these insights to guide the development of strategies and resources aimed at reducing SSI rates across Nebraska.
- The Subcommittee kindly asks for your participation in completing the survey by **October 31st**.

SCAN ME

Registration Link: **2026 APIC Nebraska Fall Conference**

AGENDA

0730 – 0745 Welcome & CBIC reminder for IPU

0745 – 0845 Leadership - *Dr. Mark Bergeron, Neonatologist CommonSpirit Health*

0845 – 0930 Break and Vendor Fair

0930 – 1030 Small Job Big Risk: Infection Prevention Leading ICRA Oversight: *Amanda Brown and Christa Mardau, Carpenters Union*

1030 – 1130 Special Pathogens – *Dr. Angela Hewlett and Angie Vasa RN, UNMC Infection Physician and Biocontainment RN*

1130 – 1230 Lunch and Vendor Fair

1230 – 1330 Breakout Session #1

Acute Care
Rose/Franciscan Room: Maternal Safety in Action: An L&D Subcommittee's Efforts to Reduce Cesarean Surgical Site Infections – *Angel Plueger, RN Infection Preventionist CUMC Bergan Mercy*

Long Term Care
Friendship Room: HAI in Long Term Care - *Dr. Salman Ashraf, Nebraska Department of Health and Human Services HAI/AR Team*

1300 – 1430 Breakout Session #2

Acute Care

Rose/Franciscan Room: IPC in the OR - *Tammy Strait, RN CHI Health St. Elizabeth Surgical Services* Educator

Long Term Care

Friendship Room: Ethical Infection Prevention and Control Exploring the APIC/IPAC Ethical Infection Prevention and Control (EIPAC) Decision-Making framework - *Deb Burdsall, PhD, RN-BC, Infection Preventionist and Manager Baldwin Hill Solutions LLC*

1430 – 1445 Break and Snack

1445 – 1545 AI – *Jen Vogelsberg, MLS (ASCP) Manager of Infection Prevention Nebraska Medicine*

1545 – 1600 Thank you & Closing remarks

Upcoming NE ICAP Webinars

Wednesday, October 14, 2026

12:00–1:00 PM (CST)

U.S. Antibiotic Awareness Week (USAAW) Promotion

Jenna Preusker, PharmD, BCPS, BCIDP

Matt Miller, PharmD, BCIDP

Wednesday, November 11, 2026

12:00–1:00 PM (CST)

To Be Determined (TBD)

NE ICAP Monthly Webinars

Infection Prevention Webinar Series for Hospital & Outpatient Settings

When: 12:00 PM – 1:00 PM (CST)
Occurs: 2nd Wednesday of every month

Hospital & Outpatient Webinar Invite Information

Infection Prevention Webinar Series for Post-Acute and Long-Term Care Settings

When: 12:00 PM – 1:00 PM (CST)
Occurs: 2nd Thursday of every month

Long Term Care Facility Webinar Invite Information

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

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 open the NE ICAP Contact Form.
Through this form, you can:

- **Request to connect with an Infection Preventionist who specializes in your area**
- **Join our setting-specific communication lists for webinar and training updates**
- **Sign up for newsletters and reminders**
- **Request an ICAR visit for your facility**

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Webinar CE Process

1 Nursing Contact Hour is awarded by Nebraska ICAP

- Nebraska Infection Control Assessment and Promotion Program is approved as a provider of nursing continuing professional development by the 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 completed by the individual earning the credit, only one person per survey.
- Survey functionality is lost on mobile devices.
- One certificate is issued quarterly for all webinars attended.
- Certificate comes directly from ICAP via email.