

Guidance and responses were provided based on information known on 10.08.2026 and may become out of date. Guidance is being updated rapidly; users should look to CDC and NE DHHS guidance for updates.

NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

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

October 8, 2026



NEBRASKA INFECTION CONTROL ASSESSMENT AND PROMOTION PROGRAM

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

Continuing Education Disclosures

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

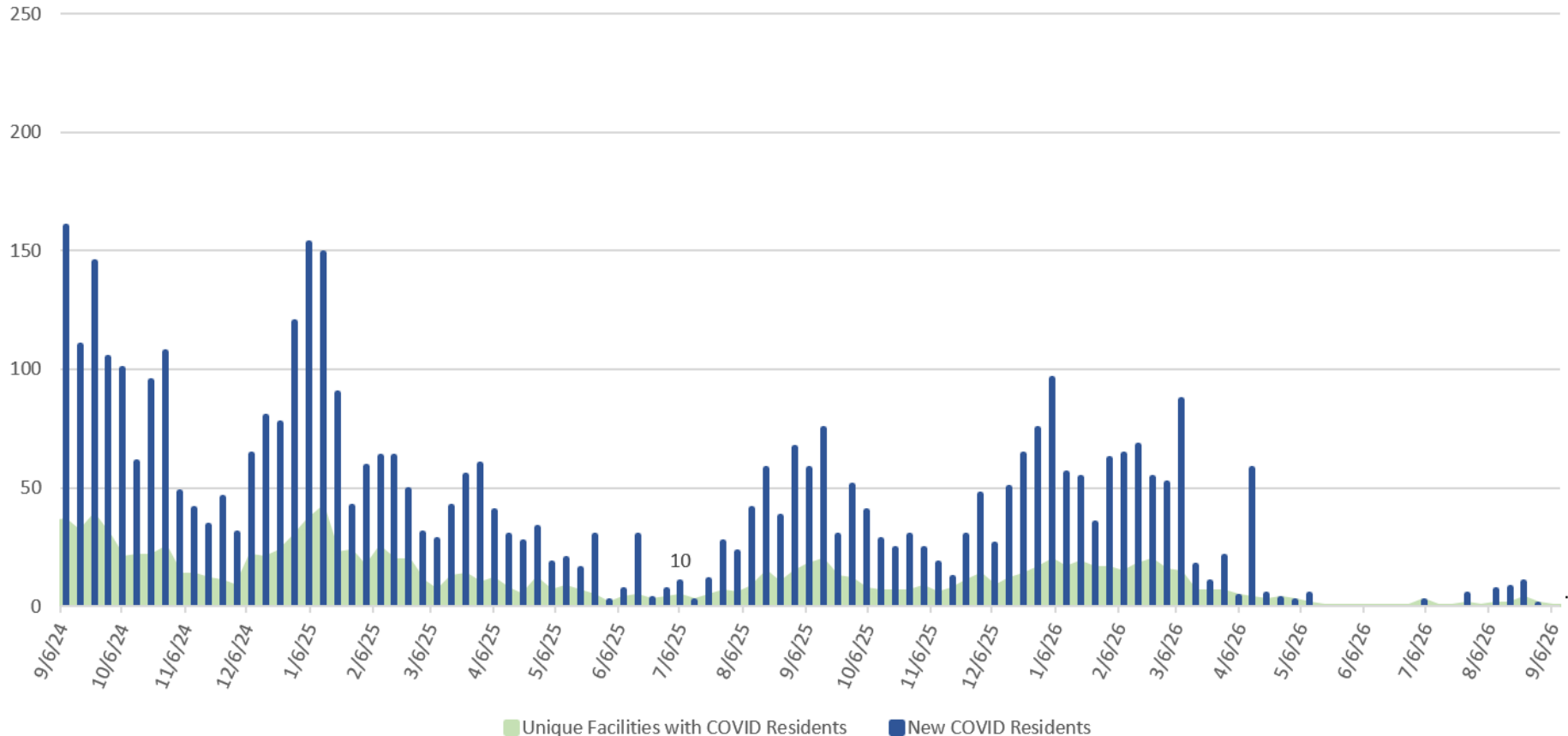


Communicable Illness Update



Nebraska LTC Facility COVID-19 Outbreaks

Nebraska LTC - Facilities with at Least One COVID Resident &
Total COVID Residents by Week



**Updated: 9/6/2026

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

National Wastewater Data

Time Period: September 20, 2026 - September 26, 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**.

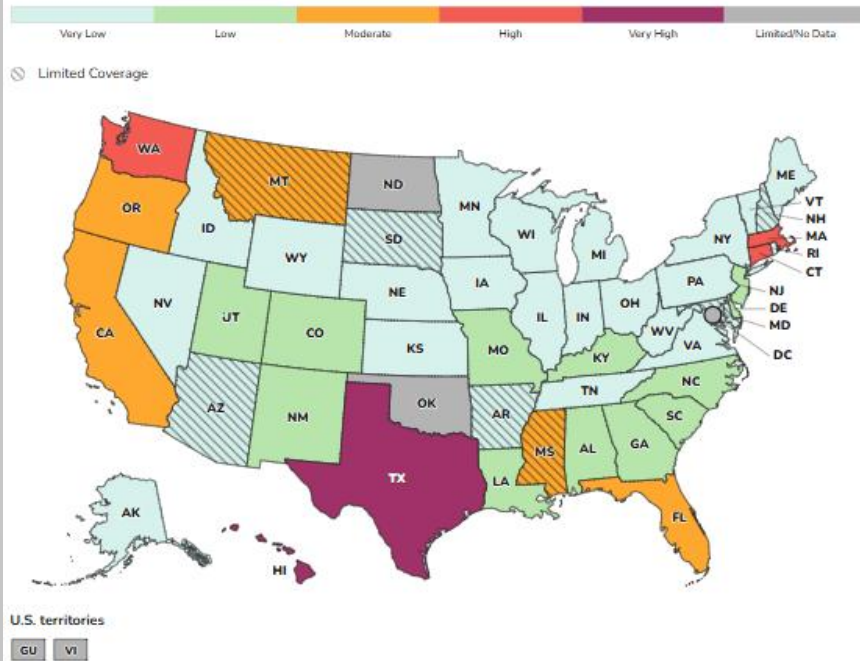


<https://www.cdc.gov/wastewater/respiratory-viruses/national.html>

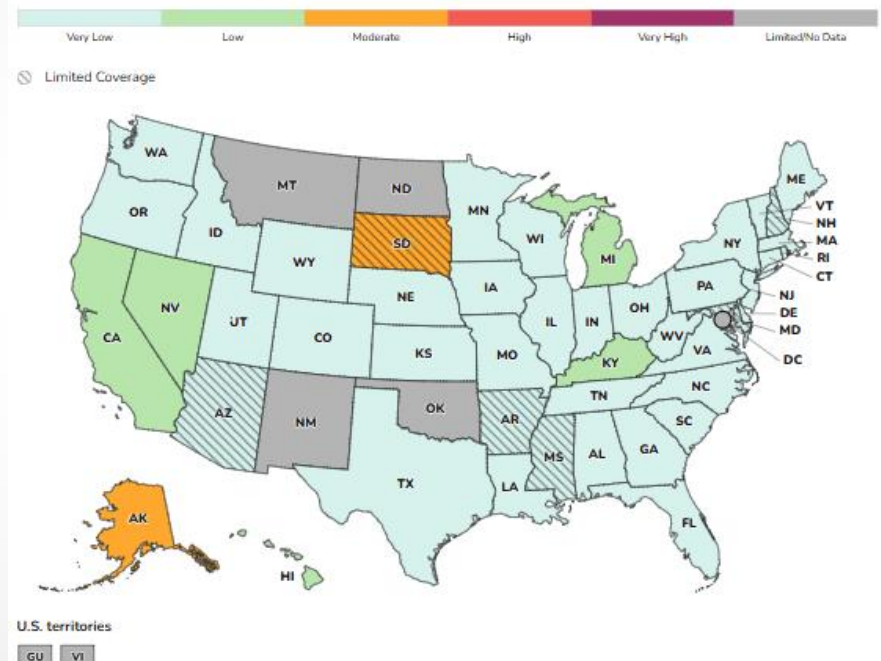
National Wastewater Activity

Time Period: September 20, 2026 - September 26, 2026

COVID-19 Wastewater Viral Activity Levels

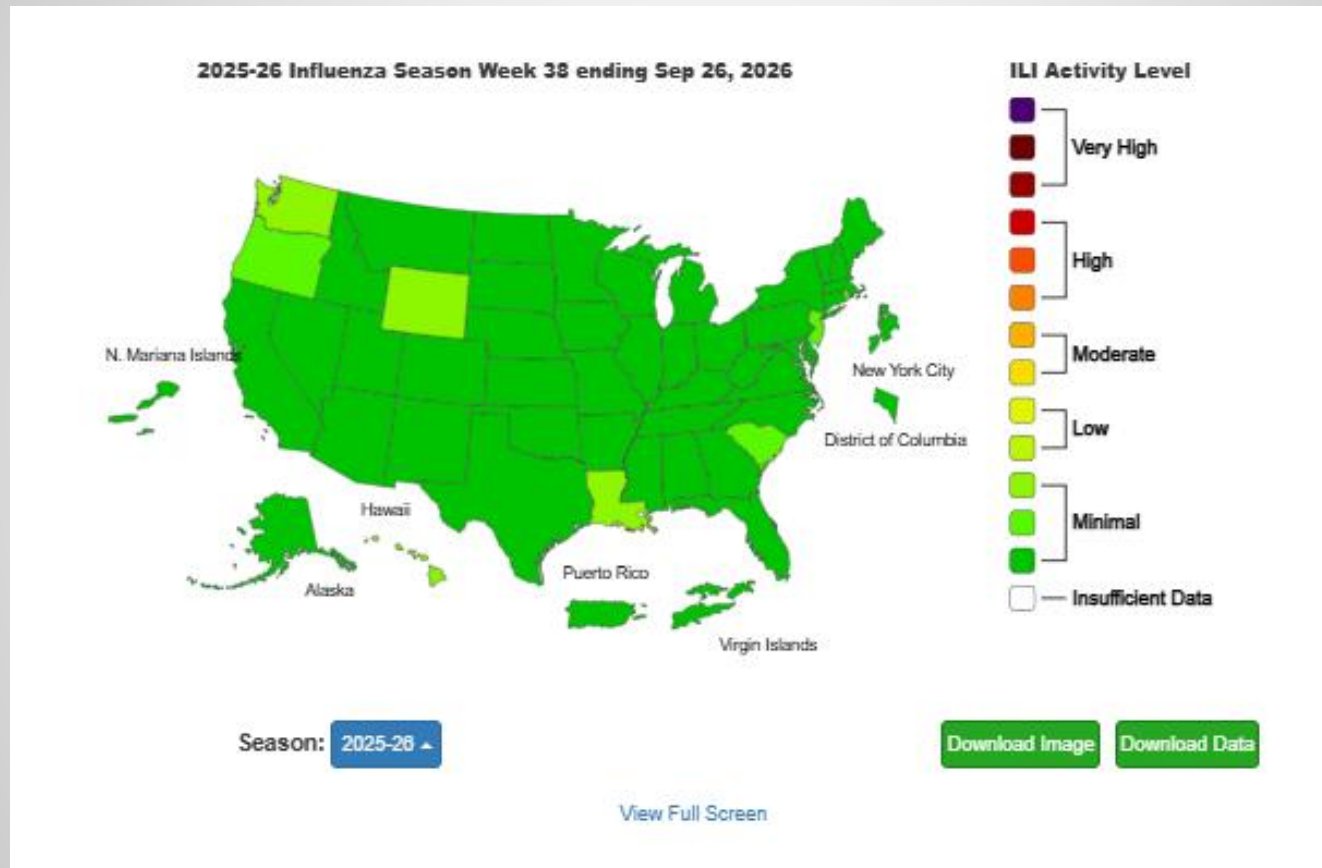


Influenza A Wastewater Viral Activity Levels



<https://www.cdc.gov/wastewater/respiratory-viruses/national.html>

CDC Weekly US Map: Influenza



<https://www.cdc.gov/fluview/surveillance/usmap.html>

CDC Update – Archived Documents

The CDC recently archived the following SARS-CoV-2 documents that have been widely referenced during the COVID-19 pandemic:

- [Infection Control Guidance: SARS-CoV-2 | CDC Archive](#)
- [Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC Archive](#)
- [Strategies to Mitigate Healthcare Personnel Staffing Shortages | CDC Archive](#)

The following ICAP summary documents have also been archived:

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

CDC References for Managing a Viral Respiratory Case/Outbreak

CDC Guideline for Infection Control in Healthcare Personnel, Viral Respiratory Infections

- <https://www.cdc.gov/infection-control/hcp/healthcare-personnel-epidemiology-control/viral-respiratory-infections.html>

CDC Guideline for Isolation Precautions: Appendix A

- <https://www.cdc.gov/infection-control/hcp/isolation-precautions/appendix-a-type-duration.html>

CDC Viral Respiratory Pathogens Toolkit for Nursing Homes

- <https://www.cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit/index.html>

Reference Review

CDC Guideline for Infection Control in Healthcare Personnel, Viral Respiratory Infections

- This recently updated guidance recommends that staff diagnosed or suspected to have COVID-19 (or other respiratory illness such as influenza, RSV, parainfluenza, rhinovirus, human metapneumovirus, etc.) should be restricted from work until at least 3 days have passed since symptom onset (or from the date of positive test if asymptomatic), AND they have resolution of fever for at least 24 hours (without fever reducing medication), AND an improvement of symptoms.
- Upon return to work, the staff member should wear source control until at least the end of day 7, where the day of symptom onset (or positive test if asymptomatic) is day 0.
- *Note: Testing is not required for returning to work.*

<https://www.cdc.gov/infection-control/hcp/healthcare-personnel-epidemiology-control/viral-respiratory-infections.html>

Reference Review

CDC Guideline for Isolation Precautions: Appendix A

- This guidance was recently updated to include recommended PPE and duration of precautions for SARS-CoV-2.
- CDC continues to recommend that healthcare personnel don N95 or higher-level respirator, gown, gloves, and protective eyewear when providing care for a resident with known or suspected SARS-CoV-2 infection.
- CDC continues to recommend that resident(s) with mild to moderate illness that have a resolution of fever (without fever reducing medication), and an improvement of symptoms should be isolated for a duration of 10 days.
- CDC continues to recommend that residents that are moderately to severely immunocompromised or who are identified to have a severe or critical infection, may require up to 20 days of isolation. A test-based strategy can be considered to discontinue isolation for moderately to severely immunocompromised individuals.

<https://www.cdc.gov/infection-control/hcp/isolation-precautions/appendix-a-type-duration.html>

Reference Review

CDC Viral Respiratory Pathogens Toolkit for Nursing Homes

- This toolkit helps nursing home infection preventionists and leadership prepare for and respond when symptoms of respiratory viral infections occur among nursing home residents or healthcare personnel. Examples of respiratory viruses included in the toolkit include SARS-CoV-2, influenza, and RSV.
 - When an infection due to a respiratory virus is suspected in a resident or HCP, it is important to take rapid action to prevent the spread to others in the facility.
 - Perform active surveillance to identify any additional ill residents or HCP using symptom screening and evaluating potential exposures.

<https://www.cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit/index.html>

Reference Review

CDC Viral Respiratory Pathogens Toolkit for Nursing Homes

Prevention

- Vaccination
- Source Control
- Education
- Ventilation

Additional steps if initial interventions fail

- Cohort units and dedicated staff
- Limit group activities
- Limit communal dining

Initial Steps in an Outbreak

- Active surveillance
- Testing symptomatic residents and HCP
- TBP (PPE)
- Visitor considerations
- Treatment and prophylaxis

<https://www.cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit/index.html>

FAQ - Outbreak Testing

Q. Is it still recommended to perform outbreak testing on close contact exposures or more broadly?

A. CDC continues to recommend testing of residents and HCP with new respiratory illness signs or symptoms, though CDC no longer has a current reference that discusses the preferred frequency of outbreak testing of asymptomatic exposures for SARS-CoV-2.

- ICAP recommends that facilities perform an internal risk assessment to guide testing protocols upon identification of a COVID-19 case/outbreak.
- If performing asymptomatic testing, refer to the manufacturer's instructions for use to determine if the test is approved for asymptomatic testing and to identify the recommended testing cadence.

INTENDED USE

The **NEBRASKA INFECTION CONTROL ASSESSMENT AND PROMOTION PROGRAM** is a lateral flow immunoassay intended for the qualitative detection of nucleocapsid protein antigen from SARS-CoV-2 in direct anterior nasal (nares) swab samples collected by a healthcare provider from individuals who are suspected of COVID-19 within seven (7) days of symptom onset when tested at least twice over three days with at least 48 hours between tests or from individuals without symptoms or other epidemiological reasons to suspect COVID-19 when tested at least three times over five days with at least 48 hours between tests. Testing is limited to laboratories certified

FAQ – Employee Testing

Q. Is it recommended to continue to test employees with symptoms of COVID-19?

A. Yes, the Viral Respiratory Pathogens Toolkit for Nursing Homes states, "Test residents and HCP with new respiratory illness signs or symptoms."

It remains important to establish the type of outbreak and exposures that have occurred in the facility to guide decisions about treatment and prophylaxis.

Testing and diagnosis

HCP with mild symptoms of a viral respiratory infection may not be tested to confirm which pathogen is the causative agent, whereas testing may more likely be performed for those with severe illness or immunocompromise. In general, there are various types of tests for viral respiratory pathogens. Typical tests include antigen tests and nucleic acid amplification tests (NAATs) (e.g., polymerase chain reaction tests). Although antigen tests return results faster, NAATs are typically more reliable at detecting viruses, but may remain positive after a person is no longer contagious [26] [27]. Ultimately, how to test for a specific viral pathogen varies by virus, and information on recommended viral pathogen-specific tests can be found on the CDC website: [Viral Respiratory Infections | Infection Control | CDC](#)

FAQ – N95 for Source Control

Q. Should we still have staff wear N95 respirators for source control when in COVID-19 outbreak?

A. The CDC does not mention the use of N95 for source control in their current documents.

CDC continues to recommend source control on affected units or facility-wide, as an initial step to control spread of respiratory viruses during an outbreak.

FAQ – Crisis Staffing

Q. Does CDC have any recommendations for contingency and crisis staffing?

A. CDC does not cover contingency or crisis staffing in their current documents. Facilities should have their own contingency and crisis staffing plans, and make decisions based on facility risk assessment.

IPC Surveillance

Juan Teran, MD, NE ICAP Medical Director, and
Josette McConville, RN, CIC, Infection Preventionist



ICAP 12-Month Webinar Series for Post-Acute and Long-Term Care

This 12-month webinar series is designed to help participants build and lead a stronger Infection Prevention and Control (IPC) program.

- Webinars will occur the 2nd Thursday of every month at 12:00 PM CST, September 2026 through August 2027.
- Target audience: LTC facility staff that have a roll in the IPC program.
- Facility attendance at 75% of sessions (September 2026 through August 2027) will receive a certificate of recognition by ICAP and be recognized on a webinar and on ICAP's social media pages.



IPC Surveillance Definition

Infection prevention and control (IPC) surveillance is defined as the ongoing, systematic collection, analysis, and interpretation of health-related data. This data is used to plan, implement, and evaluate practices meant to control infections and communicable disease.

Process Surveillance (Audit and Feedback)

- Process surveillance is the review of practices by staff directly related to resident care.
- The purpose is to identify whether staff implement and comply with the facility's IPC policies and procedures.

Outcome Surveillance

- Addresses the criteria that the IP would use to identify and report evidence of a suspected or confirmed HAI or communicable disease.
- This process of collecting and documenting data on individual resident cases and comparing the collected data to standard written definitions (criteria) of infections.

Creating a Surveillance Plan

Once the annual risk assessment is complete, determine the surveillance methods to be employed.

- Consider time and available resources when selecting the methods to be used
- Target specific issues – select surveillance activities in which data obtained can be used to improve processes and outcomes
- Use consistent surveillance processes: defining the same steps of a process (e.g., checklist) and terms for consistency, to improve daily practice and to allow for potential internal and external benchmarking.

Sources of Data

- Daily huddle: identify residents on TBP orders, new antibiotics or treatments, acute condition changes (e.g., resident(s) with fever or other signs or symptoms suspicious for infection)
- Laboratory cultures or other diagnostic test results consistent with potential infections to detect clusters, trends, or susceptibility patterns
- Antibiotic orders
- Medication regimen review reports
- Documentation from the clinical record of residents with suspicion of an infection such as physician orders/progress notes; and/or
- Transfer/discharge summaries for new or readmitted residents for infections
- EMR reports
- Data from finance department and MDS coordinator (e.g., resident days, monthly admissions)
- Employee health records (e.g., employee vaccine compliance rates), HCP call-offs for communicable illness



Standardized Surveillance Definitions

- Surveillance definitions are not the same as a clinical diagnosis.
- Surveillance definition examples: McGeer Criteria, Loeb Criteria, NHSN
 - Identify specific conditions that qualify as infections for the purpose of surveillance data collection, as well as the calculation and reporting of infection rates
 - Any change in definition (or not using standardized definitions) can affect surveillance results and make comparison of current and historical data inaccurate.

Communicable Disease/Illness Reporting

IPs or other staff that have the responsibility for reporting resident or employee cases of communicable illness to the state or local health department should review the state guideline for reporting communicable illness and also review the facility case definition of 'cluster' or 'outbreak.'

Sample outbreak definitions:

- One case of an infection that is highly communicable (i.e., measles, TB)
- Infection trends that are 10% higher than the historical rate of infection (i.e., CAUTI, MRSA)
- Two or more cases of the same infection over a specific length of time on the same unit or other defined area (i.e., norovirus)

Reportable Conditions

Infection and Antibiotic Tracking Tool



Infection and Antibiotic Start Log Collections

[Nebraska ASAP Infection and Antibiotic Use Tracking Tool 2025 Version 2](#)

[Nebraska ASAP Infection and Antibiotic Tracking Tool Instructions](#)

[Infection & Antibiotic Use Tracking Tool Video](#)

Resident Information				Classification		History					Diagnostics			
Resident ☐	Resident Name ☐	Unit Name ☐	Room ☐	Infection Type ☐	Surveillance Definition Met? ☐	Symptom(s) ☐	Symptom Onset Date ☐	Device Type ☐	Date of Insertion ☐	Date of Removal ☐	Test Date ☐	Specimen Source ☐	Culture Results ☐	MDRO or Pathogen of Consequence ☐

Antimicrobial Starts										
Antibiotic Name	Provider	Antimicrobial Rx Origin	Antibiotic Start Date	Antibiotic End Date	Loeb Criteria Met?	Antibiotic Reassessment (Antibiotic "Time outs" Performed?)	Antivirals or Antifungals Prescribed Name	SBAR Status	Infection Prevention Precautions Implemented	Date Symptom Resolved

Frequently Asked Questions

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

To accurately document antibiotic use in this situation, there should be a separate record/row for each antibiotic with the Resident name (and associated resident information) replicated for each entry. Individual records for each antibiotic allow for different start/end days. Also, because this Resident has a single infection, only include the Infection Type on the first entry; the Infection Type should be blank for the related entries. This will provide accurate count of the net number of infections.

[Tools and Templates for Long Term Care - ASAP](#)

Images from Tracking Tool Video

Resident Information				Classification		History					Diagnostics				
Resident ID	Resident Name	Unit Name	Room #	Infection Type	Surveillance Definition Met?	Symptom(s)	Symptom Onset Date	Device Type	Date of Insertion	Date of Removal	Test Date	Specimen Source	Culture Results	MDRO or Pathogen of Consequence	Antibiotic
452664	Boyd, Magdalena	South	212	Upper Resp. Tract	Yes	malaise, cough	5/10/25	No Devices			5/10/25	Throat	GAS		Amoxicillin
12445	Walter, Kelley	North	211	Cellulitis/Soft Tissue/Wound	Yes	warmth, drainage	5/11/25	No Devices				No Culture Taken			Linezolid
2255	Cuevas, Cara	East	111	Cellulitis/Soft Tissue/Wound	No	redness, swelling	5/12/25	No Devices				No Culture Taken			Sulfamethoxazole
17887687	Dickson, Carmen	West	301	Upper Resp. Tract	No	elevated respiration, lethargic	5/13/25	No Devices				No Culture Taken			Amoxicillin/Clav
46016	Colon, Ronald	West	206	Upper Resp. Tract	Yes	cough, malaise, SOB	5/14/25	No Devices			5/14/25	Throat			Amoxicillin
38711	Andrade, Lesley	South	109	Gastroenteritis	Yes	diarrhea multiple episodes	5/15/25	No Devices			5/15/25	Stool	C diff		Vancomycin
1225	Stout, Troy	South	110	UTI	Yes	frequency, urgency, burning	5/16/25	No Devices			5/16/25	Urine	E. Coli	MRSA	Fosfomycin
111	Perez, Esther	West	111	Upper Resp. Tract	No	cough, malaise, SOB	5/17/25	No Devices				No Culture Taken			Levofloxacin
45295	Gamble, Alexander	South	120	Other	No	admission from hospital on IV antibiotics	5/18/25	No Devices							Daptomycin
544	Franklin, Queen	East	203	Upper Resp. Tract	No	elevated temp	5/19/25	No Devices				No Culture Taken			Ciprofloxacin
756482	Rowland, Lauren	North	207	UTI	No	increased confusion	5/20/25	No Devices			5/25/25	Urine	Kleb pneumo		Sulfamethoxazole
12354	Robo, Jenny	South	109	UTI	Yes	Urgency, burning	1/25/25	No Devices			1/25/25	Urine	E. Coli		Fosfomycin
12354	Robo, Jenny	South	109		No	redness, swelling	1/25/25	No Devices				No Culture Taken			Amoxicillin

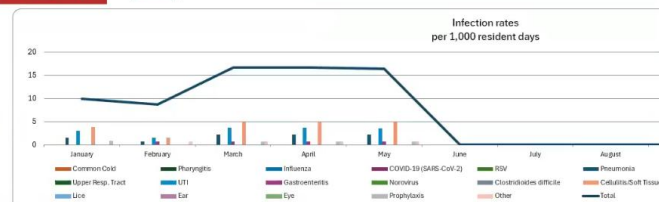
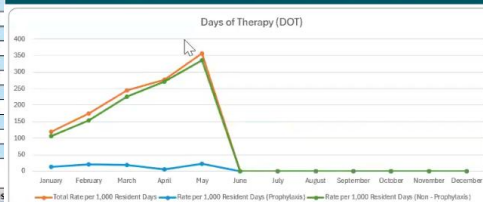
NEBRASKA ANTIMICROBIAL STEWARDSHIP ASSESSMENT AND PROMOTION PROGRAM



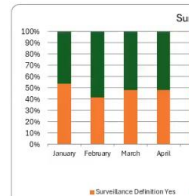
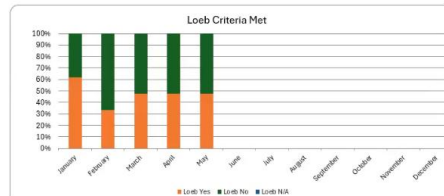
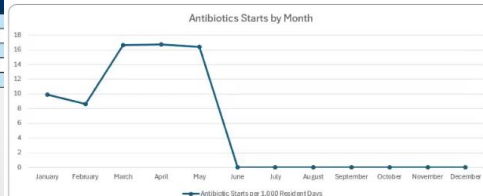
Total Days of Therapy						
Month	Total Days of Therapy per Month	Total Rate per 1,000 Resident Days	Days of Therapy (Prophylaxis)	Rate per 1,000 Resident Days (Prophylaxis)	Days of Therapy (Non - Prophylaxis)	Rate per 1,000 Resident Days (Non - Prophylaxis)
January	156	118.9	17	13.0	139	105.9
February	243	174.2	28	20.1	215	154.1
March	338	244.4	27	19.5	311	224.9
April	383	277.2	8	5.8	374	271.4
May	500	356.9	31	22.1	469	334.8
June	129				129	
July	11				11	
August						
September						
October						
November						
December						
Total	1,759	256.1	111	16.2	1,648	239.9

Antibiotic Starts by Month		
Month	Antibiotic Starts	Antibiotic Starts per 1,000 Resident Days
January	13	
February	12	
March	23	
April	23	
May	23	
June		
July		
August		
September		
October		
November		
December		
Total	94	

NEBRASKA ANTIMICROBIAL STEWARDSHIP ASSESSMENT AND PROMOTION PROGRAM



Total Infection Rates							
Month	Total	Common Cold	Pharyngitis	Influenza	COVID-19 (SARS-CoV-2)	RSV	Pneumonia
January	9.9						
February	8.6						
March	16.6						
April	16.7						
May	16.4						

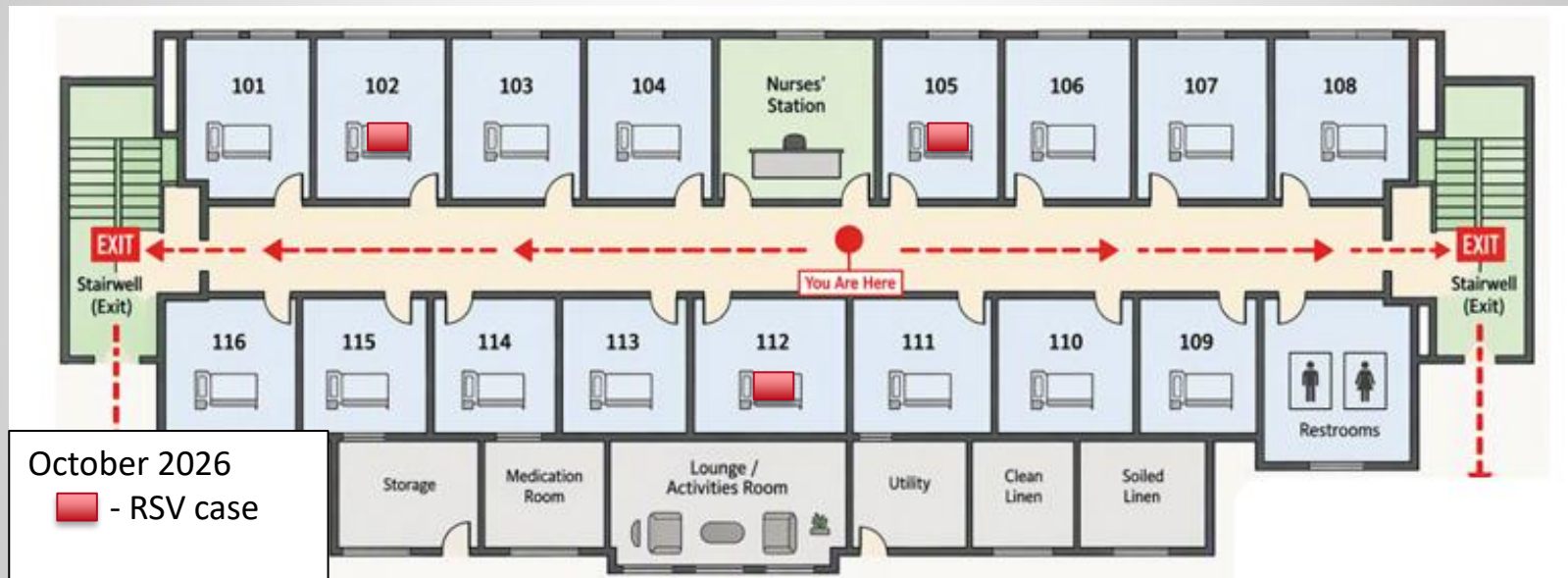


Tools and Templates for Long Term Care - ASAP

NEBRASKA INFECTION CONTROL ASSESSMENT AND PROMOTION PROGRAM



Identify Clusters



Practical Implementation

- Implementation of IPC and stewardship interventions for urinary tract infection
- Surveillance is an essential step
- The following scenarios walks you through initial assessment, program development, surveillance, and reporting

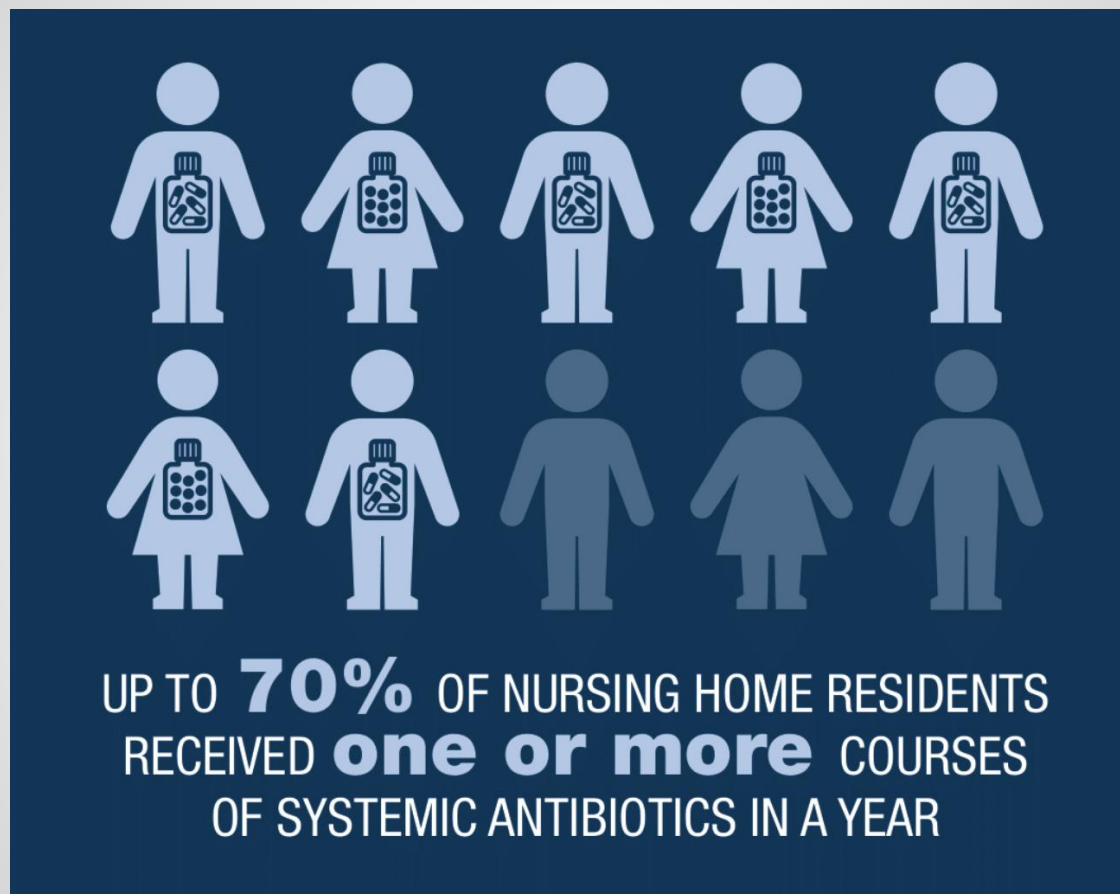
Clinical Scenario

- You are a newly hired Infection Preventionist at a 50-bed skilled nursing facility. Some of your responsibilities include antimicrobial stewardship and working with the consultant pharmacist. You noticed the following gaps:
- No written statement of support from leadership for an antimicrobial stewardship program (ASP).
- Stewardship is not part of your role description.
- The only current stewardship-related practice is that the consultant pharmacist conducts antibiotic time-outs.
- Recognizing these gaps, you want to schedule a meeting with facility leadership to advocate for implementing a formal ASP.
- How can you effectively make your case?



[New nursing home](#). Mike Coates. [CC0 1.0](#)

Why Does it Matter?



CDC. The Core Elements of Antibiotic Stewardship for Nursing Homes. Atlanta, GA: US Department of Health and Human Services, CDC; 2015

UTI is the most frequent infection

– Antibiotic overuse is common

Table 3. Antimicrobials Used by Site of Infection for Treatment of Active Infection or Medical Prophylaxis^a

Site of infection	Antimicrobials, No. (%)	
	Treatment of active infection (n = 1120) ^b	Medical prophylaxis (n = 262) ^b
Urinary tract	315 (28.1)	107 (40.8)
Skin or wound	264 (23.6)	36 (13.7)
Respiratory tract	189 (16.9)	28 (10.7)
Bone or joint	133 (10.1)	27 (10.3)
Gastrointestinal tract	88 (7.9)	Not applicable

^a More than 1 site of infection could be documented for an antimicrobial.

^b For treatment of active infection, the value indicates 77.0% of the total, and for medical prophylaxis, 18.0%

Thompson et al. Antimicrobial Use in a Cohort of US Nursing Homes, 2017. *JAMA*. 2021;325(13):1286–1295.

Clinical Scenario

- Your meeting with leadership went great. They are concerned by how often antibiotics are prescribed, and how frequently they are used inappropriately. They asked how the facility can improve the diagnosis of UTI and suggested implementing a standardized communication tool such as SBAR (Situation, Background, Assessment, Recommendation).
- Several options were discussed during the meeting. Which of the following would you recommend?
 - a) Use an SBAR format based on McGeer Criteria for UTI diagnosis
 - b) Use an SBAR format based on Loeb's Minimum Criteria for initiating antibiotics
 - c) Allow providers to use their own clinical criteria but require documentation in the medical record
 - d) I'm not sure what the difference is between A and B



[CDC Phil.](#) Public Domain

Loeb vs McGeer

- **Loeb Minimum Criteria for Initiating Antibiotics**
 - Clinical criteria are meant to **inform decisions on individual patients** when care is needed
 - When these criteria are used for clinical decision making (e.g., to start an antibiotic), clinical information (e.g., diagnostic test results, condition duration) is often unknown.
 - When criteria are met, there is reasonable expectation that the resident has an infection
- **McGeer Criteria**
 - Surveillance criteria are used to **count true case events** (i.e., diagnosed infections) and to estimate the actual incidence/prevalence of disease conditions
 - These criteria are applied retrospectively (after the fact), often with new information (e.g., diagnostic culture results, which can take days to receive) that was not available during initial clinical assessment

<https://www.health.state.mn.us/diseases/antibioticresistance/hcp/asp/ltc/loebmcgeer.pdf>

McGeer Criteria

Table 2. Urinary Tract Infection (UTI) Surveillance Definitions

Syndrome	Criteria	Selected Comments*
UTI without indwelling catheter	Must fulfill both 1 AND 2. ☐ 1. At least one of the following sign or symptom ☐ Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate ☐ Fever or leukocytosis, and ≥ 1 of the following: ☐ Acute costovertebral angle pain or tenderness ☐ Suprapubic pain ☐ Gross hematuria ☐ New or marked increase in incontinence ☐ New or marked increase in urgency ☐ New or marked increase in frequency ☐ If no fever or leukocytosis, then ≥ 2 of the following: ☐ Suprapubic pain ☐ Gross hematuria ☐ New or marked increase in incontinence ☐ New or marked increase in urgency ☐ New or marked increase in frequency ☐ 2. At least one of the following microbiologic criteria ☐ $\geq 10^5$ cfu/mL of no more than 2 species of organisms in a voided urine sample ☐ $\geq 10^2$ cfu/mL of any organism(s) in a specimen collected by an in-and-out catheter	The following 2 comments apply to both UTI with or without catheter: • UTI can be diagnosed without localizing symptoms if a blood isolate is the same as the organism isolated from urine and there is no alternate site of infection • In the absence of a clear alternate source of infection, fever or rigors with a positive urine culture result in the non-catheterized resident or acute confusion in the catheterized resident will often be treated as UTI. However, evidence suggests that most of these episodes are likely not due to infection of a urinary source. • Urine specimens for culture should be processed as soon as possible, preferably within 1-2 h • If urine specimens cannot be processed within 30 min of collection, they should be refrigerated and used for culture within 24 h

https://www.pharmacy.umaryland.edu/media/SOP/wwwpharmacyumarylandedu/centers/lamy/antimicrobial-stewardship/mcgeer-criteria-for-infection-surveillance-checklist_form.pdf

Loeb's Minimum Criteria

For Residents Without a Urinary Catheter

- ☐ Dysuria

OR

- ☐ Fever ($>100^{\circ}\text{F}$ or $>2^{\circ}\text{F}$ above baseline)

AND at least one of the following symptoms that is new or worsening:

- ☐ Urgency
- ☐ Frequency
- ☐ Suprapubic pain
- ☐ Gross hematuria
- ☐ Costovertebral angle tenderness
- ☐ Urinary incontinence

For Residents With a Urinary Catheter or if Nonverbal

One or more of the following ***without another recognized cause:***

- ☐ Fever ($>100^{\circ}\text{F}$ or a 2°F increase from baseline)
- ☐ New costovertebral angle tenderness
- ☐ Rigors
- ☐ New-onset delirium*

****If adequate workup for other causes of delirium has been performed and no other cause for delirium is identified***

Assessment and Management of the Resident With a Suspected Urinary Tract Infection. Content last reviewed June 2021. Agency for Healthcare Research and Quality, Rockville, MD.

Do's and Do Not's Pocket Card

- ☐ Send a urinalysis (UA) & urine culture (UCx)
- ☐ Increase hydration
- ☐ Start antibiotics before UA and UCx results, if resident appears ill
- ☐ If UA & UCx are positive and the resident has ongoing UTI symptoms, modify antibiotics or start antibiotics (if not receiving active antibiotics)

Assessment and Management of the Resident With a Suspected Urinary Tract Infection. Content last reviewed June 2021. Agency for Healthcare Research and Quality, Rockville, MD.

Do's and Do Not's Pocket Card

– Cont.

Do NOT Send a Urinalysis and Urine Culture:

- ☐ If the urine is foul smelling or cloudy, without other urinary symptoms
- ☐ Routinely after urethral catheter change
- ☐ Routinely upon admission
- ☐ After treatment to “document care” or “test of cure”
- ☐ For mental status changes (without vital sign changes or urinary symptoms for noncatheterized residents)

Assessment and Management of the Resident With a Suspected Urinary Tract Infection. Content last reviewed June 2021. Agency for Healthcare Research and Quality, Rockville, MD.

Successful Implementation

Sample SBAR Tool for Suspected Urinary Tract Infection



Mr. Walker MRN 74646327

S	Situation I am concerned about a suspected UTI for the above resident.
B	Background Indwelling catheter ☒ Yes ☐ No If yes, ☒ Urethral ☐ Suprapubic Incontinence ☐ Yes ☒ No If yes, is this new or worsening ☐ Yes ☐ No UTI in last 6 months ☒ Yes ☐ No If yes, Date: <u>3/13/25</u> Organism: <u>Proteus mirabilis</u> Treatment: <u>cephalexin</u> Active diagnosis (especially bladder, kidney, genitourinary conditions; diabetes; receiving dialysis, anticoagulants): _____ Advance directives for limiting treatment (especially antibiotic use): <u>No</u> _____ Medication allergies: _____
A	Assessment Vital signs: BP <u>165/85</u> HR <u>72</u> Resp. rate <u>18</u> Temp. <u>101.5</u> O ₂ Sats. <u>98</u>

Resident WITH indwelling catheter The criteria are met to initiate antibiotics if one of the following are selected: No Yes ☐ ☒ Fever of 100°F (38°C), or 2°F (1.1°C) above baseline, or repeated temperatures of 99°F (37°C) ☐ ☒ New back or flank pain ☐ ☒ Rigors / shaking / chills ☐ ☐ New onset delirium (new dramatic change in mental status) ☐ ☐ Hypotension (significant change in baseline BP or SBP <90) ☐ ☐ Acute suprapubic pain ☐ ☐ Acute pain, swelling or tenderness of the scrotal area	Resident WITHOUT indwelling catheter Criteria are met to initiate antibiotics if one of the three situations are met: No Yes ☐ ☐ Any one of the following two: ☐ Acute dysuria alone (pain or burning while urinating) ☐ Acute pain, swelling or tenderness of the scrotal area OR ☐ ☐ Single temp of 100°F (38°C), or 2°F (1.1°C) above baseline, or repeated temperatures of 99°F (37°C) <u>and</u> at least one of the following new or worsening symptoms: ☐ Urgency ☐ Suprapubic pain ☐ Frequency ☐ Gross hematuria ☐ Back or flank pain ☐ Urinary incontinence OR ☐ ☐ No fever, but two or more of the following new or worsening symptoms: ☐ Urgency ☐ Suprapubic pain ☐ Frequency ☐ Gross hematuria ☐ Urinary incontinence
---	---

Successful Implementation

R	Recommendation	
	☒ Protocol criteria met. Resident may require UA and urine culture or an antibiotic. ☐ Protocol criteria are NOT met. Resident DOES NOT need immediate antibiotic but may need additional observation.	
	Nurse's Signature: Nurse Debby Summit _____ ☐ Notification of Family/POA Name: _____ ☐ Faxed or ☒ Called to: Dr. John Steward _____ By: Nurse Summit _____ Date/Time: 5/30/25 _____	Date/Time: 5/30/25 _____ Date/Time: _____

Physician Orders/Response (Please check all that apply)

☒ I have reviewed the above SBAR.

- ☒ Urine culture (if indicated)
☒ Encourage 4oz of cranberry juice or another liquid (_____) for _____ times/day, until symptoms resolve
☐ Record fluid intake & output until symptoms resolve (output can also be measured from urinal or by weighing diapers, etc.)
☒ Assess vital signs, including temp; every 4 _____ hours for 24 _____ hours
☐ Monitor and notify PCP if symptoms worsen or unresolved in _____ hours
☒ Other: Exchange Foley catheter prior to urine culture _____
☒ For antibiotic orders (if needed) please complete script below:



Drug: Ceftriaxone _____ Dose: 2g _____ Route: IV _____ Frequency: Daily _____ Duration: 72 h _____ Indication: CAUTI _____

Physician Signature: Dr. Steward _____	Date/Time: 5/30/25 _____
--	--------------------------

Please Fax Back To: _____ or ☐ Telephone Order

File Under Physician Order/Progress Notes

Clinical Scenario

After implementing your UTI SBAR based on Loeb's criteria, you educated staff for 2 months on this new tool and saw a 25% reduction in UTI antibiotic starts the following quarter. Leadership is pleased and has allocated stewardship FTE for further work with the consultant pharmacist.

Now, you review an SBAR for Ms. Barnes, a healthy 63-year-old woman with no catheter. She met Loeb's criteria with dysuria, urgency, and hematuria, and was started on nitrofurantoin for 7 days by Dr. Steward. You checked on her on day 3, and she still has symptoms, but her urine culture, which resulted on day 2, shows no growth. Her treatment plan has not changed.

What do you recommend?

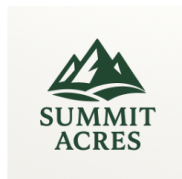
- a) Continue treatment as per Dr. Steward's recommendations.
Antibiotics may take time to work
- b) Implement a formal antibiotic time-out so plans can be adjusted
- c) Ask the medical director to broaden coverage



[CDC PHIL 23257](#). Robert Denty. Public Domain

Antibiotic Time-Out

SBAR Communication Tool Template for Antibiotic Time-Out



Ms. Barnes MRN 5498131

S	Situation: I am calling to follow-up on [resident's name: <u>Ms. Barnes</u>] who was started on antibiotic(s) recently.
B	Background: This patient was started on: Antibiotic #1: <u>Nitrofurantoin 100mg BID</u> Start date: <u>5/27/30</u> Antibiotic #2: _____ Start date: _____ For: ☒ UTI ☐ Pneumonia ☐ Bronchitis ☐ Skin infection ☐ GI infection ☐ Fever of unknown source ☐ Other, specify: _____ Vitals at initial presentation were as follows: BP <u>136</u> / <u>80</u> HR <u>100</u> Resp. rate <u>18</u> Temp. <u>97.5</u> O₂ Sats. <u>98</u> Symptoms and positive exam findings at that time were: <u>Dysuria, urgency, Hematuria</u> The diagnosis fits: ☐ McGeer criteria ☒ Loeb criteria ☐ Neither ☐ Assessment tool not used
A	Assessment: Current vital signs: BP <u>140</u> / <u>84</u> HR <u>98</u> Resp. rate <u>18</u> Temp. <u>97</u> O₂ Sats. <u>99</u> Since starting antibiotic(s), the resident: ☐ now has <u>no</u> signs or symptoms of infection ☒ has remained the same ☐ has improved but continues to have signs and symptoms of: _____ ☐ has <u>new or worsening</u> signs/symptoms of: _____ Microbiology culture result (fax microbiology report if available): ☐ has not returned yet ☒ has <u>no</u> growth ☐ was not obtained ☐ has positive Gram stain/growth of [specify Gram stain/microorganism: _____] Is susceptible to the antibiotic(s) prescribed: ☐ Yes ☐ No ☐ Don't know ☐ Not tested by lab ☐ Not yet performed by lab Other antibiotics the organism is sensitive to: _____

Antibiotic Time-Out

R	Recommendation:		
	☒ Patient is not improving and needs further evaluation. ☐ Patient has improved and needs final antibiotic therapy plan.		
	Nurse's Signature: Nurse Debby Summit _____		Date/Time: 5/30/25 _____
	☐ Faxed or ☒ Called to: Dr. John Steward _____ By: Nurse Summit		Date/Time: 5/30/25 _____

Physician Orders/Response (Please check all that apply)

☒ I have reviewed the above SBAR.

☐ Continue current antibiotic to complete a total antibiotic course of _____ days. Specify Antibiotic End date: _____ ☐ Change antibiotic therapy to: Drug: _____ Dose: _____ Route: _____ Frequency: _____ Duration: _____ ☒ Stop antibiotic now ☒ Other (Please specify): <u>Send to CT scan with clinical suspicion for kidney stones</u> _____
--

Physician Signature: Dr. Steward

Date/Time: 5/30/25

Please Fax Back To: _____ or ☒ Telephone Order

Created by Phil Chung, PharmD, MS, BCPS and Salman Ashraf, MBBS

Clinical Scenario

- You are reviewing urine culture results to assess the prevalence of ESBL-producing organisms in your facility. During the review, you observe that over a quarter of urine cultures are polymicrobial, growing three or more organisms, an indicator that may suggest contamination.
- Further investigation reveals that your facility lacks standardized policies and procedures for proper urine culture collection. In response, you decide to audit current collection practices to identify areas for improvement and reduce contamination rates.

Urine Collection for Patients with Chronic Indwelling Urinary Catheter

If possible, change the urinary catheter before collecting a sample. Especially for those in place for more than 2 weeks or for an unknown period

Hand hygiene and sterile gloves

If there is no urine in the tube, clamp the tube for 15-30 minutes prior to the procedure

Clean the collecting port with alcohol wipe prior to access

Insert a 10 cc syringe at an angle into the port. Draw back 3-5 ml

Insert specimen into sterile container

Date, label, time the specimen. Transfer to lab or refrigerator within 15 minutes

Urine Collection for Patients Without Catheters

Consider collecting urine after the resident has taken a bath, or use a sponge rinse with soap and water

Midstream clean-catch is the preferred method

In-and-out catheterization

Clean genital area as described above

Perform catheterization using sterile technique

Alternative to in-and-out catheterization for men: place and obtain a specimen from a new condom catheter. Check the collection bag every 30 minutes

Surveillance

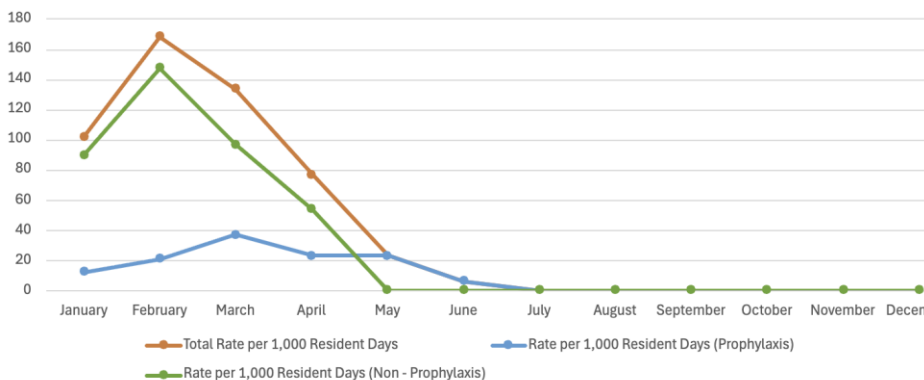
Resident Information			Classification		History				
Unit Name	Resident Name	Room	Infection type	Surveillance definition met?	Symptom(s)	Symptom Onset Date	Device Type	Date of Insertion	Date of Removal
200		222	UTI	No	lethargic, fever, AMS	1/17/24	No Devices		
100		114	UTI	Yes	repeat fall, AMS, hematuria	1/26/24	No Devices		
100		109	UTI	Yes	repeat fall, AMS	1/26/24	No Devices		
100		110	UTI	Yes	frequency, urgency, burning	2/15/24	No Devices		
200		207	UTI	No	increased confusion	2/22/24	No Devices		
100		128	Prophylaxis - UTI	No	repeated UTIs	N/A	No Devices		
100		130	UTI	Yes	dysuria, fevers	3/1/24	No Devices		
200		207	UTI	Yes	fever, suprapubic pain	4/2/24	No Devices		

Diagnostics				Antimicrobial Starts						
Test Date	Specimen Source	Culture Results	MDRO or Pathogen of Consequence	Antibiotic Name	Provider	Antimicrobial Rx Origin	Antibiotic Start Date	Antibiotic End Date	Loeb Criteria Met?	Antibiotic Reassessment (Antibiotic "Time outs" Performed?)
	No Culture Taken			Cefdinir	Brown, Dr. Pamela	Long-term Care Center	1/17/24	1/27/24	No	No
1/26/24	Urine	E. Coli	ESBL	Nitrofurantoin	Brown, Dr. Pamela	Long-term Care Center	1/26/24	1/31/24	Yes	No
1/26/24	Urine	E. Coli		Levofloxacin	Smith, Dr. William	ED	1/26/24	2/4/24	N/A	Yes
2/15/24	Urine	E. Coli	ESBL	Fosfomycin	Static, Dr. Kathy	Clinic	2/15/24	2/18/24	Yes	Yes
2/23/24	Urine	Kleb pneumo	No	Sulfamethoxazole/Trimethoprim	Brown, Dr. Pamela	ED	2/22/24	2/28/24	N/A	No
				Sulfamethoxazole/Trimethoprim	Starr, Dr. Enrique	Clinic	3/1/24	6/8/24	N/A	No
3/1/24	Urine	E. Coli	ESBL	Levofloxacin	Brown, Dr. Pamela	Long-term Care Center	3/1/24	3/8/24	Yes	Yes
4/3/24	Urine	E. Coli	ESBL	Nitrofurantoin	Brown, Dr. Pamela	Long-term Care Center	4/3/24	4/8/24	Yes	Yes

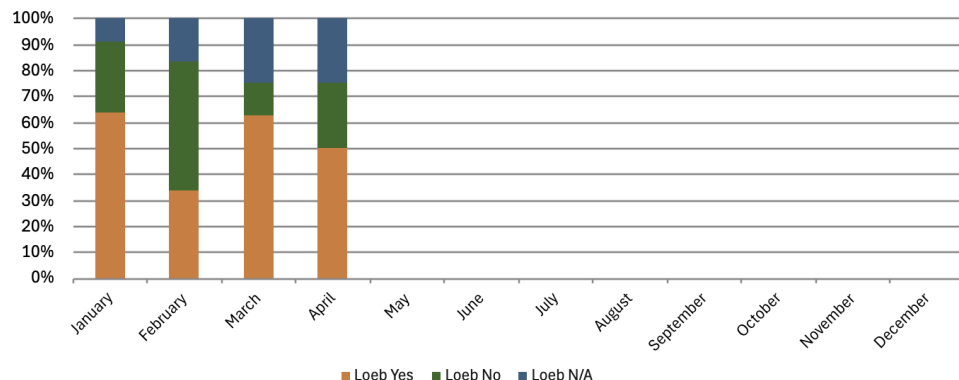
SBAR Status	Infection Prevention Precautions Implemented	Date Symptom Resolved
Not Used	Standard precautions only	1/27/24
Complete	Standard precautions only	1/31/24
Not Used	Standard precautions only	2/4/24
Complete	Standard precautions only	2/18/24
Not Used	Standard precautions only	3/3/24
Not Used	Contact precautions	N/A
Complete	Standard precautions only	3/6/24
Complete	Standard precautions only	4/7/24

Reporting

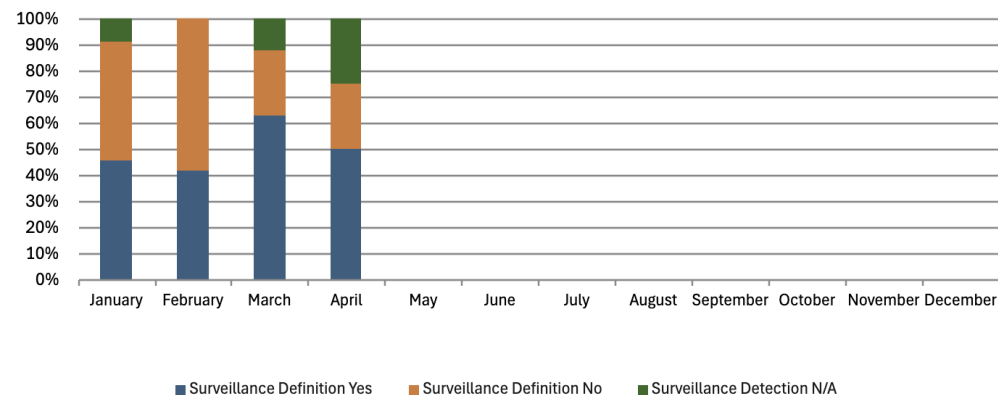
Days of Therapy (DOT)



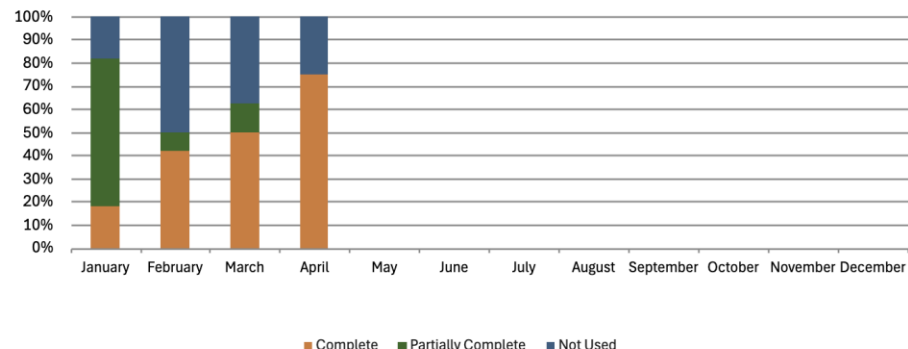
Loeb Criteria Met



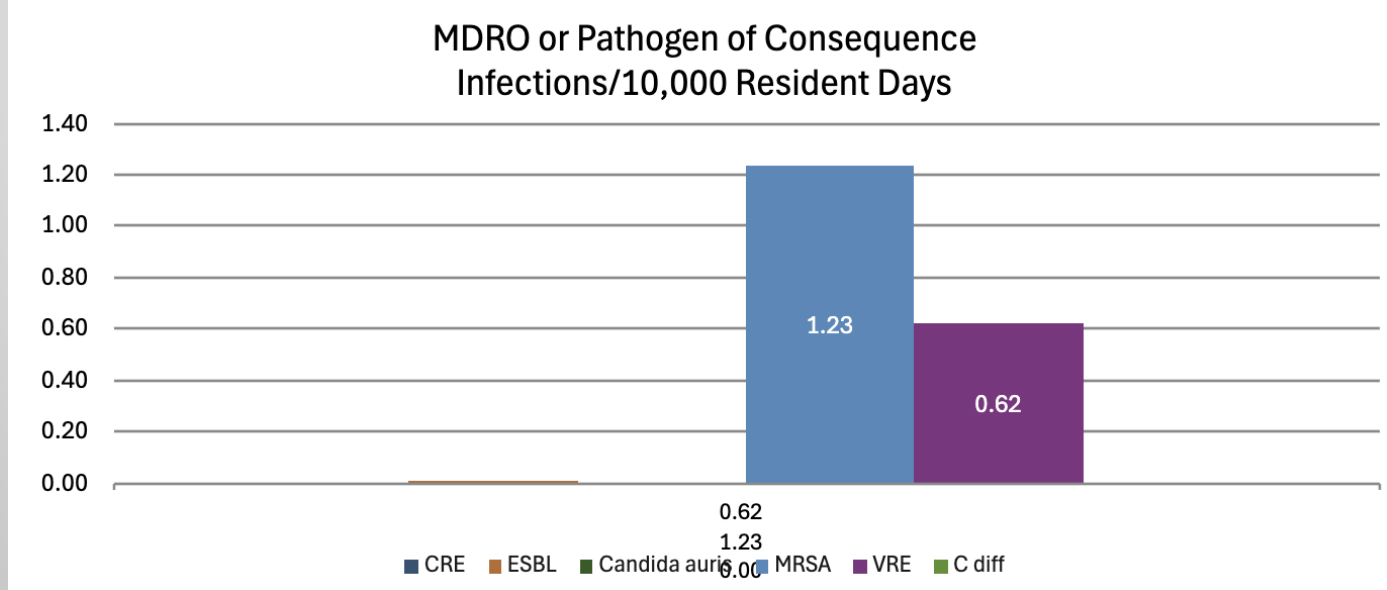
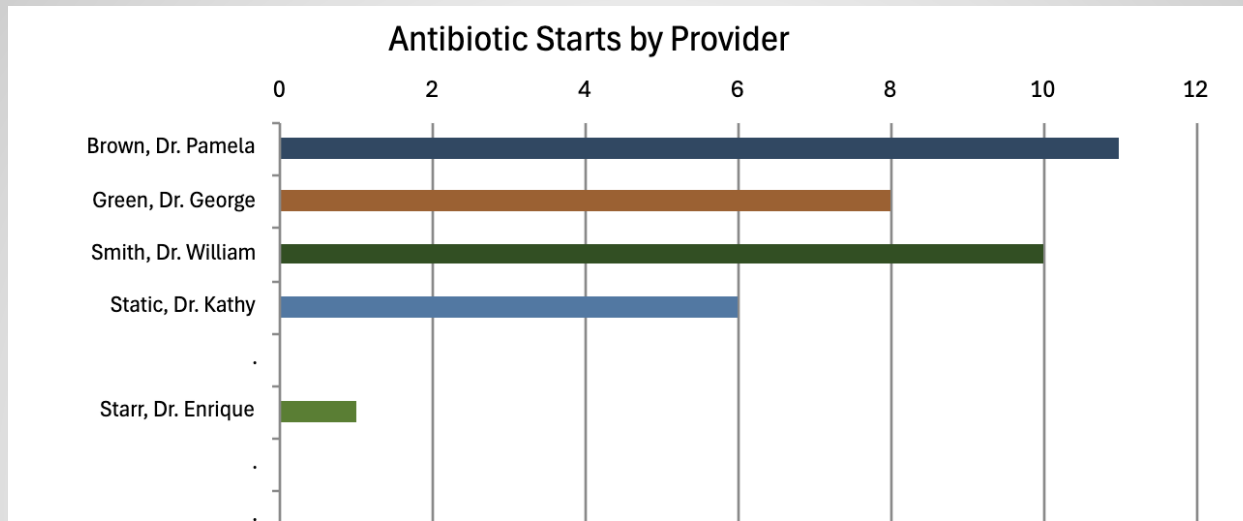
Surveillance Definition



SBAR Status



Reporting







U.S. Antibiotic Awareness Week

**November
18–24, 2026**

The purpose of the observance is to raise awareness of the importance of appropriate antibiotic and antifungal use and the threat antimicrobial resistance poses to people, animals, plants, and their shared environment.



[Link to Resources: U.S. Antibiotic Awareness Week \(USAAW\)](#)

How can LTCFs participate?

- Share information with staff, residents, and family members
 - [Patient Education Resources](#)
- Participate in Nebraska ASAP trivia
- Promote on internal websites/intranet/social media
- Sign up for the Nebraska ASAP LTC Antibiotic Use Collaborative
- Newsletter articles
- Highlight recent accomplishments of your LTC antibiotic stewardship teams
- Wear purple!

More ideas and resources:

[U.S. Antibiotic Awareness Week \(USAAW\) Toolkit](#)

Go Purple for USAAW

- CDC is inviting families, friends, organizations, and communities to shine a spotlight on antimicrobial resistance by participating in Go Purple for USAAW.
- This nationwide effort encourages individuals to wear purple and bring purple to their social media and invites organizations, healthcare facilities, and municipalities to light up buildings and landmarks purple to bring awareness to the role everyone has in combating antimicrobial resistance.



[U.S. Antibiotic Awareness Week \(USAAW\) | Antimicrobial Resistance | CDC](#)

Long-Term Care Antibiotic Use Collaborative

- Started in 2025
- Currently 42 (~20% of all Nebraska NH) are enrolled
- Infection preventionists or consultant pharmacists report data monthly via Redcap
- Commonly use data sources by facilities include EHR infection control module or Antibiotic use logs
- Facilities receive quarterly reports
- Facilities also have an option to ask for 1:1 feedback meeting

NEBRASKA ANTIMICROBIAL STEWARDSHIP ASSESSMENT AND PROMOTION PROGRAM 

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

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

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

As part of this collaborative, the Facility agrees to:

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

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

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

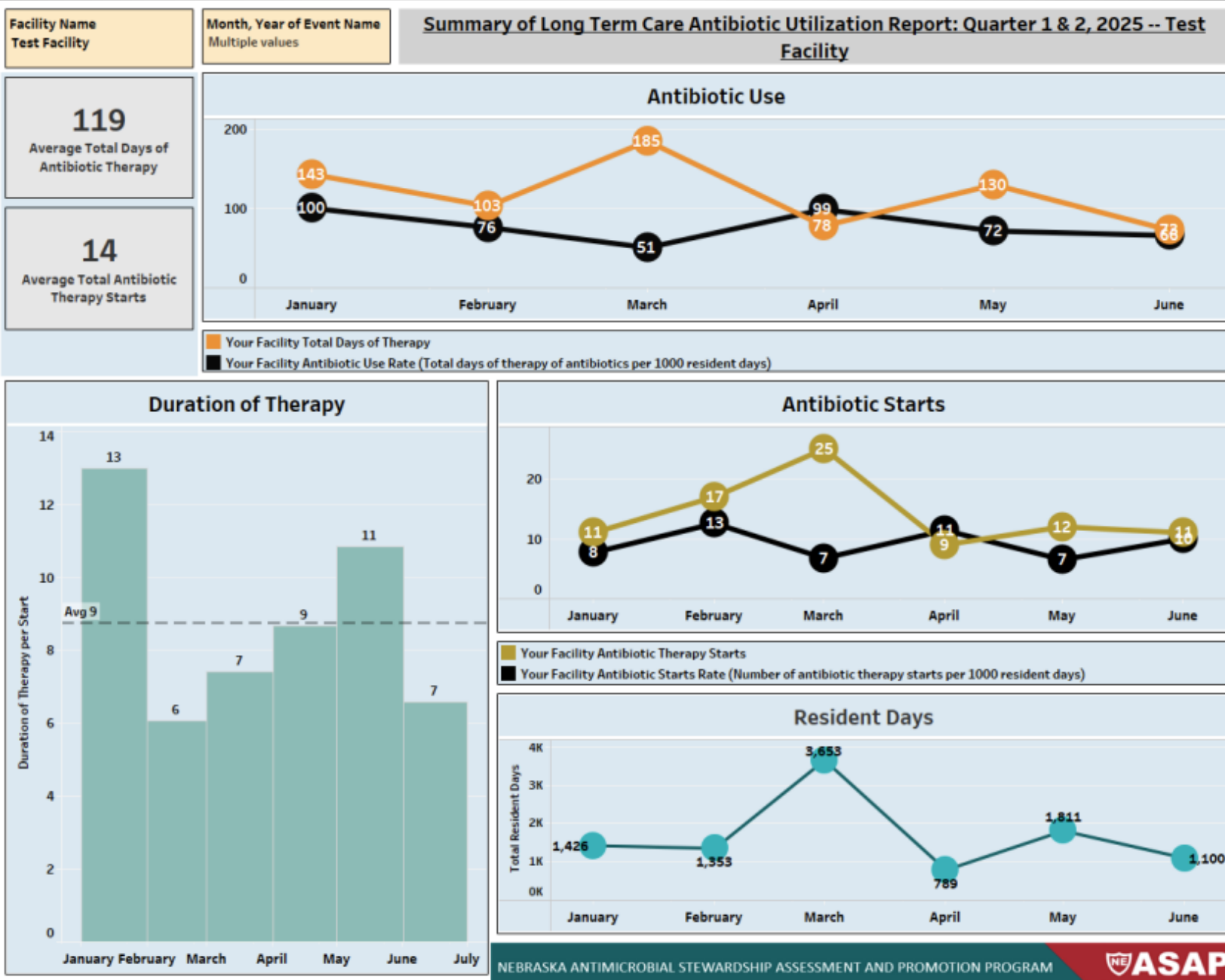
Participating facilities will expect Nebraska ASAP to:

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

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

Signature of Facility Representative	_____	Title	_____
Printed Name	_____	Date	_____

Sample Quarterly Report: Facility Level Data – Page 1



Note: Fictitious data for illustration purposes only

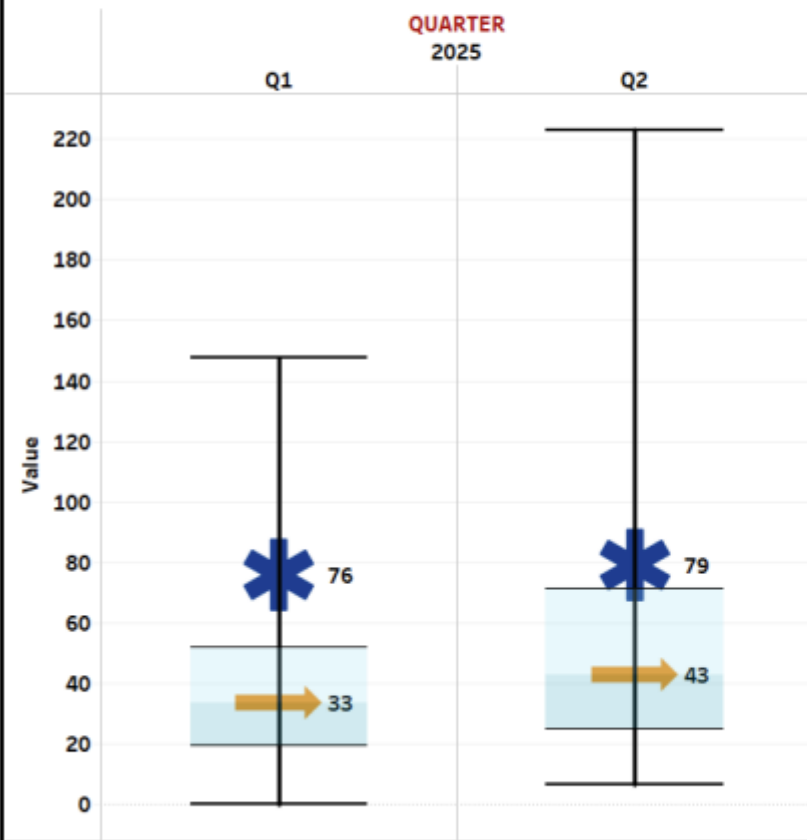
Sample Quarterly Report: Comparative Data – Page 2

Antibiotic Use and Starts Benchmarking Report - Test Facility

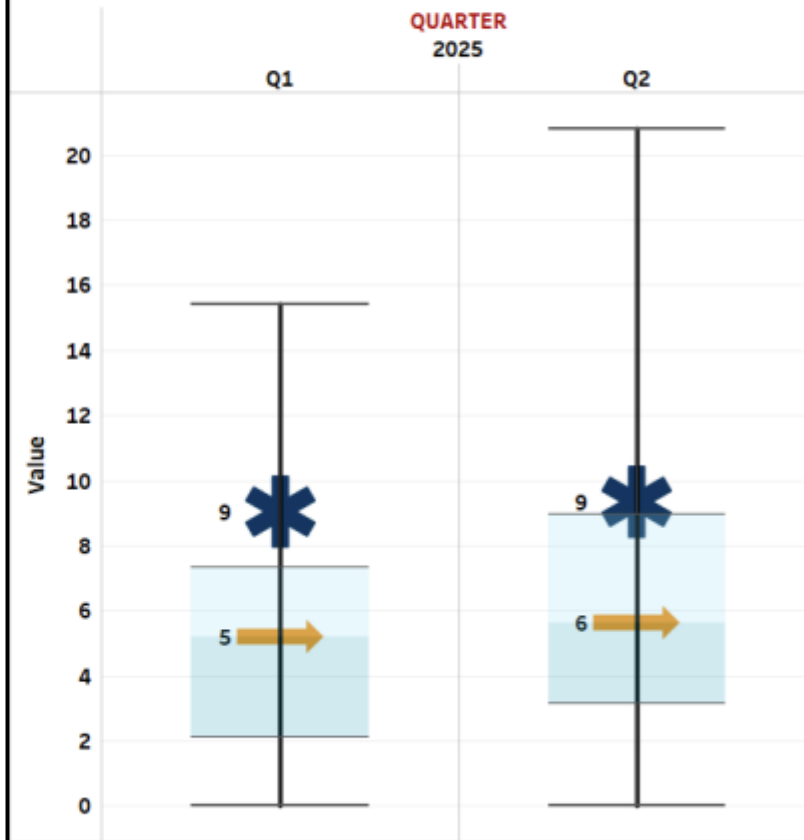
Select Facility
Test Facility

The graphs display the facility's average Antibiotic Use Rate and Antibiotic Starts Rate by Quarter. It also displays the statewide median use and start rates, and range, by quarter for all LTCFs that reported 1 or more months. Antibiotic use rate for each facility was calculated by dividing total days of therapy by total resident days*1000. Antibiotic starts rate for each facility was calculated by dividing total number of antibiotic starts by total resident days*1000.

Antibiotic Use Rate by Quarter



Antibiotic Starts Rate by Quarter



* Your Facility's Use Rate or Start Rate → Statewide Median

Note: Fictitious data for illustration purposes only

Nebraska State & Regional Antibioqram Report

NEBRASKA DHHS HEALTHCARE-ASSOCIATED INFECTIONS AND
ANTIMICROBIAL RESISTANCE PROGRAM

NEBRASKA STATE ANTIBIOGRAM REPORT 2025



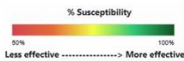
Published August 2026

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M. Salman Ashraf, MBBS

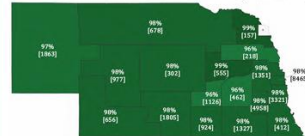
Escherichia coli

The maps below display the percent susceptibility and the number of isolates included by local health department jurisdiction. Red indicates less effective drug-bug combinations, and darker green indicates more effective combinations. * indicates insufficient data to report (<10 isolates or <50% of susceptibility data available for the drug-bug combination)

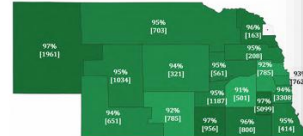


Nitrofurantoin

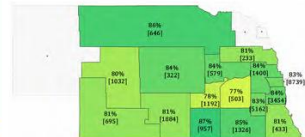
Note: Nitrofurantoin is indicated for treatment of uncomplicated urinary tract infection only.



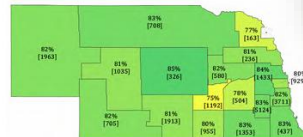
Ceftriaxone



Levofloxacin

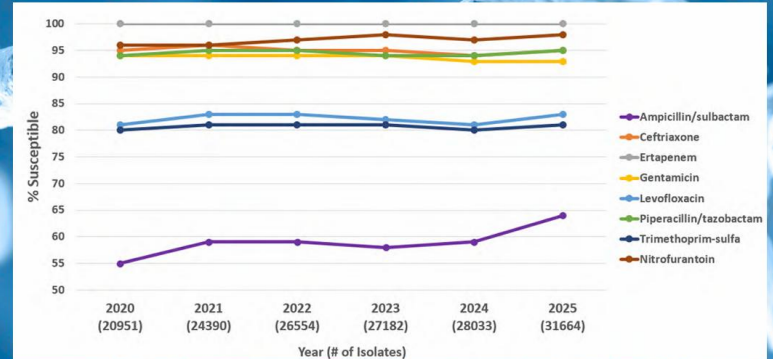


Trimethoprim-Sulfamethoxazole



- Data collected from electronic lab reports submitted to the Nebraska Electronic Disease Surveillance System (NEDSS)
- Report Includes
 - Nebraska Statewide Antibioqram
 - Local Health Department Antibioqrams
 - Susceptibility Heat Maps by LHD
 - Trends in Antibiotic Susceptibility, 2020–2025

Escherichia coli



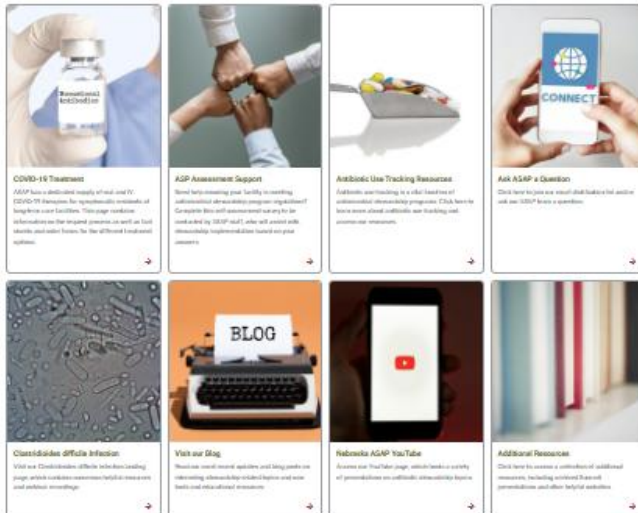
[Link: 2025 Nebraska Antibioqram Report](#)



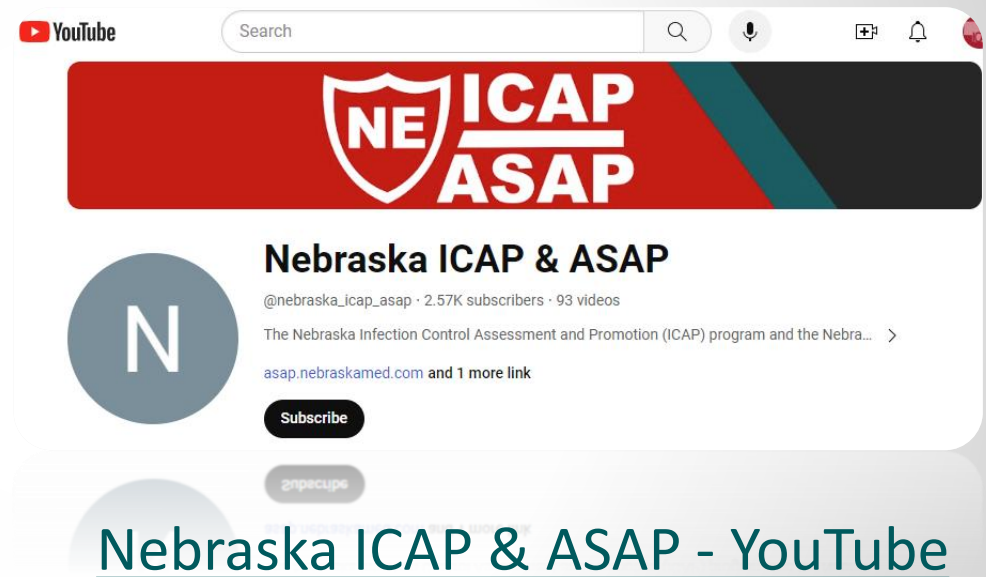
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ASAP Website and YouTube channel




<https://asap.nebraskamed.com/>





LONG-TERM CARE ANTIBIOTIC STEWARDSHIP TOOLKIT

NEBRASKA ANTIMICROBIAL STEWARDSHIP ASSESSMENT AND PROMOTION PROGRAM



[Link: Antibiotic Stewardship Toolkit - ASAP](#)

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Nebraska ASAP Newsletter: *The* *Antimicrobial Advocate*

THE ANTIMICROBIAL ADVOCATE

Volume 3: Issue 5/6
May/June 2026



New Drug Approval

On June 17, the FDA approved **Utebzi** (tebipenem pivoxil) tablets as the first oral carbapenem therapy for complicated urinary tract infections, including pyelonephritis. The most common side effects are diarrhea, headache, nausea, abdominal pain, increased liver enzymes, and *C. difficile* infection.

[Link to FDA Approval](#)

Comprehensive Review of *Candida auris* Management: Insights From the Society of Infectious Diseases Pharmacists

[Click Here for the Full Article](#)

Summary

- Candida auris* has emerged as a health threat due to its multi-drug resistance, persistence in healthcare environments, and rapid spread.
- Its ability to tolerate heat, salinity, and disinfectants and form biofilm allows long-term survival on surfaces and medical devices, facilitating transmission.
- Clinical presentations range from asymptomatic colonization to invasive infections, with mortality rates approaching 50%.

Treatment Considerations

Echinocandins remain an important first-line treatment option, but their fungistatic activity, limited tissue penetration, and emerging resistance contribute to suboptimal outcomes, highlighting the need for new agents and optimized dosing strategies.

Triazoles and amphotericin B are significantly limited by resistance and toxicities, while newer agents such as ibrexafungerp, fosmanogepix, and rezafungin show promising in vitro activity but lack substantial supporting clinical data.

Combination therapy may also offer potential benefit, though supporting evidence is sparse. Table 2 contains therapy considerations by site of infection.

Ongoing efforts to refine antifungal therapy, improve rapid diagnostics, and strengthen infection control are essential to mitigating spread and optimizing outcomes for patients.

Knowledge and Skills for Antibiotic Stewardship Leaders

This guidance from SHEA, IDSA, PIDS, and SIDP outlines the knowledge and skills necessary to lead ASPs, organized by **basic, intermediate, and advanced** skills recommended for stewards practicing in acute care, outpatient care, and long-term care settings. *Use the table to complete the gap analysis in the article supplement to structure both a personal and program development plan.*



Link to the Guidance

Basic	Intermediate	Advanced
- Establishing structure/staffing - Programmatic elements and interventions - Regulatory standards for AUAR tracking/reporting 1-3 years	- Maintain basic components - Expanded capabilities and resources - More complex initiatives 3-5 years	- Maintain basic and intermediate components - Expansion of footprint into other healthcare areas - Multi-state/site initiatives - Advocacy efforts >5-7 years

Key Points

- Clinical expertise + stewardship leadership readiness
- Skill gaps differ by practice setting
- Structured development plans accelerate success
- The gap analysis can be completed on a regular basis (annually) to track progress and reinforce the importance of intentional leadership development.

Cefazolin vs. Antistaphylococcal Penicillins for MSSA Bacteremia

For years, clinicians have debated cefazolin vs. antistaphylococcal penicillins for methicillin-susceptible *Staphylococcus aureus* (MSSA) bacteremia. A major randomized controlled trial from the SNAP trial group was published in NEJM that provides practice-changing evidence.

Link to the Article

Cefazolin was noninferior for 90-day mortality: 15% vs. 17% with flucloxacillin/cloxacillin	Cefazolin had less acute kidney injury: 13.9% vs 19.6%	Fewer serious adverse reactions and fewer treatment discontinuations were seen with cefazolin
---	--	---

- This trial provides strong evidence supporting cefazolin as an effective option for MSSA bacteremia that is safer for kidney function.
- Cefazolin should be considered a first-line treatment for MSSA bacteremia over nafcillin or oxacillin, when clinically appropriate.



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Guidance for Knowledge and Skills of Antibiotic Stewardship Leaders

[Link to Guidance](#)

Table 1. Fundamental antimicrobial stewardship knowledge and skills—Clinical Infectious Diseases

Knowledge/skill		Acute Care ^a	Out-patient	Long-term care ^a	Basic (B)	Intermediate (I)	Advanced (A)
Antimicrobials	Mechanisms of action and spectrum of activity	B, I, A	B, I	B, I	Understand differences in mechanisms of action and spectrum of activity of <i>commonly used</i> antimicrobials.	Understand differences in mechanisms of action and spectrum of activity <i>within</i> drug classes. Educate frontline prescribers about mechanisms of action and spectrum of activity of <i>common</i> antimicrobials.	Educate frontline prescribers about mechanisms of action and spectrum of activity of <i>less common</i> antimicrobials (eg those used to treat extensively drug-resistant infections).
	Drug interactions, side effects and adverse events	B, I, A	B, I, A	B, I	Understand common antimicrobial drug interactions and side effects, including adverse reactions that mimic infections.	Perform drug safety audits and root cause analyses when adverse drug events occur.	Develop electronic tools to alert providers to common drug interactions, side effects, and monitoring parameters.

- Outlines the knowledge and skills necessary to lead ASPs, specific to LTCF
- Divides into basic, intermediate, and advanced skills
- A gap assessment tool is provided in the supplemental materials link to help programs develop plans to meet goals

In Closing



CDC Video for Residents and Staff



Share this video with residents, their loved ones, and staff. Facilities can download the MP4 file to broadcast the video on their 'in-house' network or include it in staff trainings and resident welcome materials.

[Infection Prevention and Long-term Care Facility Residents | LTCFs | CDC](#)

Upcoming Webinar

November 12th, 2026 at 12:00 CST

- Hand hygiene, audit and feedback (process surveillance)

Webinar CE Process

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

Individual surveys must be completed for each attendee.

Questions? Contact us at: nebraskaicap@nebraskamed.com 402-552-2881

Nursing Contact Hours:

- Completion of survey is required.
 - The survey must be specific to the individual obtaining credit.
(i.e.: 2 people cannot be listed on the same survey)
- One certificate is issued quarterly for all webinars attended
- Certificate comes directly from ICAP via email

Infection Prevention and Control Hotline Number:

Call 402-552-2881

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

*Messages left outside of office hours will be answered the next business day.

**Please call the main hotline number to ensure the quickest response.