

PREVENTION STRATEGIST

A PUBLICATION OF
THE ASSOCIATION FOR
PROFESSIONALS IN
INFECTION CONTROL
AND EPIDEMIOLOGY

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OF INFECTION
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SPRING 2023 | vol. 16 issue 1

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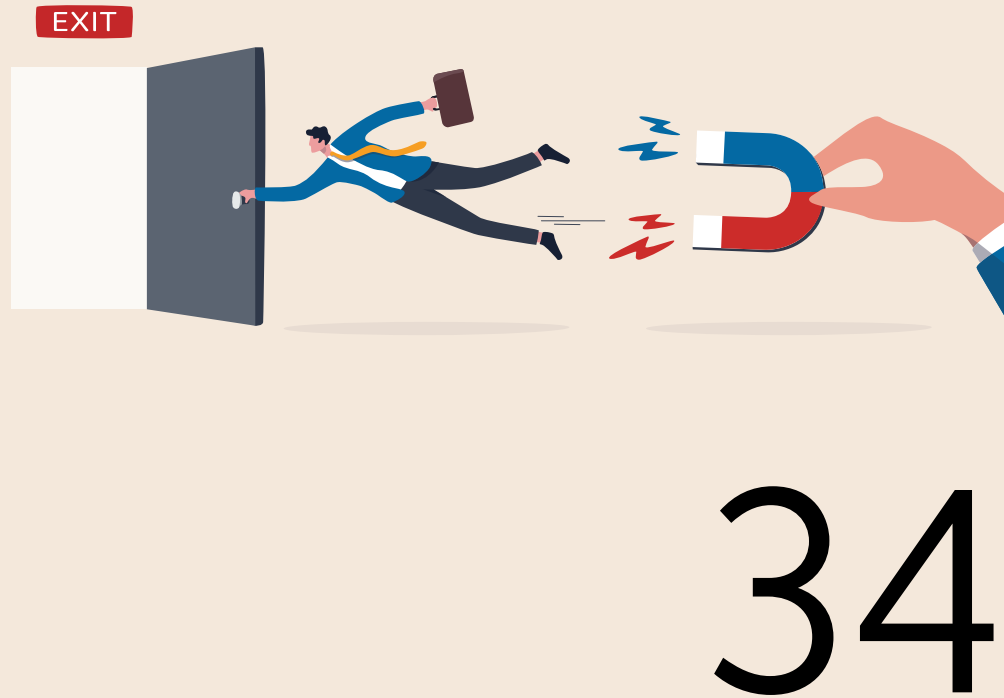
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Devin Jopp
APIC CEO

Joy and Meaning Through Infection Prevention

As I was reading through this wonderful edition of *Prevention Strategist*, I was struck by the common theme in many of the articles that discussed the burnout that many experienced during the COVID-19 pandemic, while at the same time celebrating the joy and meaning about their role and impact. As I engage with so many APIC members from around the world, in different phases of their careers and in various roles—this idea of joy and meaning is a common thread.

The desire to truly make a difference and indeed the joy of being an infection preventionist initially was a draw for IPs as they entered the profession. In talking with IPs who have retired, it's quite clear that joy and meaning sustained them throughout their career. This is certainly not to say that there are not ups and downs in the life of an IP, but that generally experiencing joy and meaning is crucial to feeling satisfied in our work and is the proverbial fuel in our tank that powers IPs.

In reading Claire Jai's journey to making a difference through her work in low-resourced areas and setting up the IP infrastructure in Africa, to Geeta Sood talking about the joy she takes in being a "CSI agent" in her work, to Luz Caicedo talking about how she fell in love with the profession during an outbreak of a multidrug-resistant organism—we can feel the joy and meaning that these IPs felt in their own career journeys.

Of course, we also know that joy and meaning were severely challenged during the COVID-19 pandemic. In 2021, APIC worked in partnership with the Ohio State University to study burnout among our IPs. As was published in *AJIC*, this study was alarming and revealed the extent of mental health and well-being trauma experienced by so many IPs.

The article in this edition of *Prevention Strategist* on stress and burnout by Brenna Doran and Reba Businsky struck a cord as I thought about how can we "rediscover" joy and meaning if it's been lost or diminished. In other words, how do we put the genie back in the bottle? The *Harvard Business Review* (HBR) tackled this topic recently with an article entitled "Rediscover Joy at Work" and those lessons resonate for IPs.

Through the pandemic, IPs faced an almost constant stream of uncertainty, along with grief over the loss of loved ones, colleagues, and patients. We were called upon to work grueling hours and to be experts who carried the burden of being "okay" for others even when we may not have been "okay." Coupling this with the social isolation we experienced, it created prime conditions for challenging our mental health and well-being and in some cases, robbing us of joy and losing sight of the meaning we initially felt.

The HBR author had some pearls of wisdom for us on our journey back on the path to joy and meaning. First, she suggests that we build strengths into our day. In other words, find the things that we enjoy doing the most and try to make some time to do tasks that energize you. Second, focus on professional growth. Look for ways to build yourself, as it creates opportunities to set meaningful goals and fulfilling those goals brings joy. Third, share with trusted colleagues. Find a network of trusted colleagues (both inside and outside of your organization) who you can open up to as a safe space to not only share challenges but also share your hopes, dreams, wins, and gratitude. Fourth, rebuild relationships through work. Joy and meaning is made as we engage with others and a powerful antidote to social isolation. Coaching too can be a form of building relationships that can have psychological benefits to both the mentor and the mentee.

As members of APIC, I want to take a moment to remind you about how you can re-discover and expand your own joy and meaning through your professional home. Build relationships locally through your chapter or in the various groups that APIC makes available nationally to establish relationships. This year APIC is also planning to offer group mentoring, which I would encourage our members to take advantage of. Again, build relationships and create a safe place to learn and grow together. Finally, take advantage of APIC's professional development courses and consider pursuing certification if you're not already certified. These educational programs can help fuel joy by helping you achieve your own professional development.

The joy and meaning that initially inspired you into the profession may have been shaken by the pandemic, but it is not broken. Take time to focus on your own joy and meaning and lean on your colleagues here at APIC to help keep the flames alive.

Devin Jopp, EdD, MS
APIC CEO

MANAGING EDITOR

Elizabeth Haberkorn
ehaberkorn@apic.org

CONTRIBUTING EDITORS

Alexis Cahill
acahill@apic.org

Elizabeth Garman, CAE
egarman@apic.org

PROJECT MANAGER

Russell Underwood
runderwood@naylor.com

ADVERTISING

Brian Agnes
bagnes@naylor.com

GRAPHIC DESIGN

Gufran Khan

EDITORIAL PANEL

Feah Altura-Visan, MAN, CIC

Anjali Bisht, MPH, CIC

Lynn M. Carosella, MSN, MA, RN, CIC

Maria Cuccinello, RN, MSN, CIC

Brenna Doran, MA, PhD, CIC

Kathryn (Katie) Galvin, MS, MLS(ASCP)CM, CIC

Imelda Garcia, RN, MSN, MHA, CIC

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Jessica L. Swain, MBA, MLT, CIC

Sarah Van Hoof, MSN, RN, CIC, FAPIC

Kezia Wallerson, MPH, MHA

Shaunté Walton, MS, MB(ASCP), CIC

CONTRIBUTING WRITERS

Reba Businsky

Alexis Cahill

Richard Capparelli

Brenna Doran

Liz Garman

Bob Hall

Nancy Hailpern

Claire Jai

Devin Jopp

Elaine Larson

Martha Sauchuk

Steven J. Schweone

Patricia Stone

Lisa Tomlinson

MISSION

Founded in 1972, the Association for Professionals in Infection Control and Epidemiology (APIC) is the leading association for infection preventionists and epidemiologists. With more than 15,000 members, APIC advances the science and practice of infection prevention and control. APIC carries out its mission through research, advocacy, and patient safety; education, credentialing, and certification; and fostering development of the infection prevention and control workforce of the future. Together with our members and partners, we are working toward a safer world through the prevention of infection.

PUBLISHED MARCH 2023 •
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**Elaine Larson, RN,
PhD, CIC**
2023 CBIC President

CBIC Celebrates 40 Years

The Certification Board of Infection Control and Epidemiology (CBIC) is celebrating its 40th anniversary this year. We look forward to seeing many of you at the APIC Annual Conference and Exposition in Orlando at our booth and at the CBIC reception. This year we will be highlighting CICs who have reached certification milestones, such as five years, and up to forty years. We will continue to spotlight certificants from around the world. I am pleased to announce we now have certificants from over 45 countries!

The year 2023 also marks the release of CBIC's revised strategic plan. Please have a look at this revised strategic by going to www.cbic.org/cbic/strategic-plan.htm on the CBIC website. Some highlights include updates to the CBIC vision and mission statements.

Vision

- A world free of infections through demonstrated professional competency.

Mission

- Provide pathways to demonstrate and maintain competence in infection prevention and control.

One of CBIC's strategic priorities includes expanded accessibility to certification for professionals responsible for infection prevention across settings. Our first action to address this strategic priority was making a change to the Associate-Infection Prevention and Control (a-IPC™) certification. The a-IPC™ was previously valid for three years and was not renewable. The a-IPC™ certification will now be valid for five years and is renewable through examination. Current a-IPC™ certificants will have their certification extended to a full five years.

Daily testing is underway for the new long-term care certification in infection prevention. Over 300 individuals were part of the beta testing in 2022. I would like to thank both the beta testers and test committee that made this exam possible. Our test committee works year-round to write and review test questions to ensure the high quality of CBIC examinations, and their work is essential.

As we head into spring, please consider the following:

- If you are not yet certified, why not? Not only is it a mark of professional distinction and accomplishment, but you will find it to be personally very gratifying.
- As a certified infection prevention and control expert, you can be an invaluable resource to support and improve the quality of the exam by volunteering to be an item writer or a future test committee member. It is an amazing experience—it's lots of work, but our item writers comment on how much they learned and enjoyed networking with colleagues. To volunteer, please check the [CBIC website at www.cbic.org/cbic/about-cbic/volunteer-opportunities.htm](http://www.cbic.org/cbic/about-cbic/volunteer-opportunities.htm) this fall and be on the lookout for an email from CBIC staff highlighting available positions.

Elaine Larson, RN, PhD, CIC
2023 CBIC President



One of CBIC's strategic priorities includes expanded accessibility to certification for professionals responsible for infection prevention across settings.



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MRSA



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2023 Leadership

APIC is governed by an elected board of directors comprised of four officers, the immediate past president, and between 9 and 12 directors. The executive committee includes the president, who serves as chair, the president-elect, the immediate past president, the treasurer, the secretary, and one at-large board member. The chief executive officer serves as a nonvoting, ex-officio member of the board of directors and the executive committee.

- The board is responsible for positioning the association to best serve APIC members, as well as maintaining the focus and vision to improve the practice and management of infection prevention.
- The board establishes policy; directs the activities of the elected officials, committees, and chief executive officer; oversees APIC's finances; and charters chapters.



President—Patricia Metcalf Jackson, RN, MA, BSN, CIC, FAPIC

Pat Jackson is the 2023 President of the Association for Professionals in Infection Control and Epidemiology. She is the Director of Infection Prevention at White Rock Medical Center in Dallas, TX. She has been an infection preventionist for the past 29 years. She has worked in both adult and pediatric healthcare facilities but considers pediatrics to be her area of expertise.

She most recently served APIC in elected roles as Treasurer and member of the Board of Directors. Pat's passion is mentoring new IPs. She served as an original author on APIC's *Roadmap for the Novice Infection Preventionist* and spent many years as a faculty member to APIC's epidemiology training courses. Pat believes we need to attract and retain the next generation of IPs in order for APIC to reach its potential.

Pat spent the majority of her career in large academic teaching hospitals. In 2022 she transitioned to a small community hospital where she became a "one-cr." She has enjoyed the small town feel of knowing everyone and has a new appreciation for the lone IP. The lone IP by their very nature becomes a master of everything and often with less than IPs at larger facilities.

Pat earned her Bachelor of Science degree from Baylor University and has been certified in infection control since 1996. In 2016 she was a member of the inaugural class of APIC fellows.



President-elect—Tania N. Bubb, PhD, RN, CIC, FAPIC

Tania Bubb is the Director of Infection Control at the Memorial Sloan Kettering Cancer Center in New York, NY, and has been an infection preventionist (IP) for 16 years. Her career has included working at four major academic medical centers with responsibilities spanning inpatient and outpatient settings. Tania's IP journey has given her an opportunity to gain foundational and advanced IP skills and develop critical thinking and leadership abilities. She has served APIC on her chapter's board of directors and has served on and chaired the APIC Professional Development Committee, the Editorial Review Board of the *American Journal of Infection Control*, APIC's Practice Resource Editorial Panel, and APIC's board of directors where she served as CBIC liaison and on the executive committee. This past year, Tania co-chaired APIC's Health Inequities and Disparities Taskforce. She is an experienced speaker and author, having presented at local and national APIC events and other conferences. Tania has authored publications related to infection prevention and control, including the APIC *Professional Practice Standards*.

Tania received her Bachelor and Master of Science Degrees in Nursing from City University of New York Herbert H. Lehman College and earned her Doctor of Philosophy Degree in Nursing from New York University.

Tania believes that leadership in infection prevention relies on influence and strategic collaboration. This approach includes promoting relationships, enhancing collaboration, including diverse perspectives, and increasing communication and awareness of important issues. It requires flexibility for change due to challenges within complex healthcare systems or external forces. Her leadership style focuses on the promotion and adoption of scientific research, strategic planning, and transparency that results in actionable processes and measures to prevent infections, leads to effective and sustainable change, and promotes the advancement of APIC and the profession.



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MS, CIC, NREMT, FAPIC



Monika Pogorzelska-Maziarz
PhD, MPH, CIC, FAPIC,
FSHEA, FACE



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MPH, CIC, FAPIC



Karoline Sperling
MLS(ASCP)CM,
CIC, FAPIC



Elizabeth (Beth) R. Wallace
MPH, CIC, FAPIC



Angela Vassallo
MPH, MS, CIC, FAPIC

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MD, MPH



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EdD

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International Infection Preventionist Day 2023

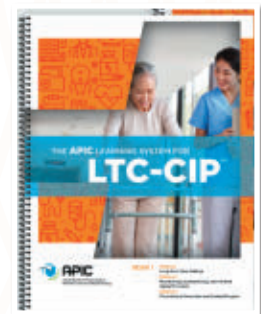
We are excited to announce that the third annual International Infection Preventionist (IP) Day will take place on April 7, 2023 (first Friday in April). IPs are essential front-line healthcare workers whose job is to keep patients, staff, and communities safe from infection. This day is an opportunity for IPs worldwide to celebrate their critical role in preventing the spread of infection and protecting public health.

International IP day is a dedicated day to acknowledge the tireless work and dedication of IPs in various settings, including hospitals, long-term care facilities, schools, and beyond. Mark your calendars, get ready to celebrate, and stay tuned for more information on how to participate in this special day for infection preventionists!

APIC Launches a New Certification Preparation Program for IPs in LTC

At the peak of the COVID-19 pandemic, 34% of deaths were linked to nursing homes. According to APIC surveys, less than 40% of IPs working in long-term care settings reported having infection prevention training and certification. APIC has taken steps to ensure its members have the proper training and certification to manage and oversee these facilities where residents are at a higher risk for contracting HAIs and experiencing complications from infection.

The new APIC Learning System for LTC-CIP (<https://learnipc.apic.org/ltc-cip-certification/>) is based on the exam content outline of the Certification Board for Infection Control and Epidemiology's (CBIC's) new Long-term Care Certification in Infection Prevention (LTC-CIP) (<https://www.cbic.org/CBIC/Long-term-care-certification.htm>). It will guide users toward successful certification through three steps—Assess, Study, and Pass—and learners will have access to a variety of online interactive study tools, such as flashcards and quizzes.



“We are really excited about the quality, the educational experience, and the depth of the content that we are offering with our new learning system,” said Letty Klutz, Vice President of Education and Events at APIC. “Learners will be able to take a pre-test to determine where they may have gaps in their knowledge so they can customize their study plans. This is a much more robust offering.”

APIC Receives Joint Accreditation Status

APIC has been awarded Joint Accreditation status (<https://apic.org/education-and-events/accreditation-and-contact-hours/>) for four years as a provider of interprofessional continuing education (IPCE) by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC).

As a provider of IPCE, APIC will now provide continuing education credits for pharmacists and physicians, in addition to nurses. There is also an opportunity to expand APIC's continuing education credit offerings to athletic trainers, dentists, dietitians, optometrists, physician assistants, psychologists, social workers, and other professionals. CEs for APIC education can now be offered to physicians, pharmacists, and nurses.

“I am delighted that APIC has received Joint Accreditation status, having the ability to expand accredited continuing education activities and profession-specific credit for nurses, physicians, and pharmacist,” said Stephanie Holley, MBA, BSN, RN, CIC, FAPIC, Director of IP Education and Professional Development at APIC. “This opportunity helps us remain committed to offering the highest quality continuing education activities for IPs and the multidisciplinary healthcare teams they work with to serve the needs of patients and the public.”



In Memoriam: Julia Garner

APIC mourns the passing of Julia Garner, RN, MN, an instrumental force in the founding and early years of APIC. Garner served on the initial steering committee that developed the framework for APIC and on its first board of directors. A nurse consultant for the CDC, she became Chief of Hospital Infectious Diseases prior to the formation of the Division of Healthcare Quality Promotion (DHQP). Garner helped develop many CDC guidelines including those for isolation precautions, handwashing and the environment, and surgical wound infections. Her team created a formal set of definitions for the surveillance of nosocomial infections, and she was influential in outlining the importance of infection control programs. Garner will be missed for her optimism and her support of the infection preventionist profession.



Julia Garner is honored by Dr. William Jarvis of the CDC, circa 1997.

PHOTO COURTESY OF CANDACE FRIEDMAN

Career Kit: A Day in the Life

APIC has developed a resources kit for colleges to introduce students to the field of infection prevention and control. The kit includes infographics and fact sheets on who IPs are, career mobility, networking, and more. Access the kit at: apic.org/careers-in-infection-prevention-and-control/.

Day in the Life of an IP

MEET:

Katelyn Harms, MPH CIC
Infection Prevention Program Manager
UnityPoint Health-Meriter, Madison, WI



Each day will bring variety and require problem solving. An IP is often asked to adjust priorities and be flexible for urgent needs.

	COFFEE AND EMAILS — 7:00 AM – 7:15 AM	DISEASE SURVEILLANCE
		Review labs, identify reportable communicable diseases, investigate possible hospital acquired infections.
	UNIT ROUNDDING — 8:30 AM	
	Connect with care teams to review any cases of concern or assist with education.	
	LUNCH — 12:00 PM	
	SURPRISE! — 1:00 PM	
<i>The things you don't plan for, amiright?</i>	An unexpected mumps case was diagnosed in the ER.	
	Assist staff with appropriate isolation precautions, report the case to public health, and conduct an exposure workup for the staff involved in the care.	
	ORGANIZE — 3:00 PM	
	Review emails, work requests, and prepare presentation materials for tomorrow's meetings.	
		EDUCATION
		Teach new employee orientation! Covering topics like hand hygiene, isolation, and PPE. Emphasize how to keep our patients and staff safe.
		CONSTRUCTION BARRIER CHECK
		Work with construction crew to inspect a newly renovated space before its opened back up to patient use. We check overall cleanliness and air quality before signing off.
		QUALITY IMPROVEMENT
		Facilitate a meeting with various team members in the OR to discuss recent surgical site infections. Discuss areas of concern and opportunities for improvement.

AJIC Impact Factor Jumps Between 2020 and 2022

The *American Journal of Infection Control's* (AJIC) impact factor has substantially increased to 4.303 from 2.918 in 2020. The Journal Impact Factor is published each year by Clarivate Analytics. It is a measure of the number of times an average paper in a particular journal is cited during the preceding two years.

AJIC is APIC's official scientific journal.

Access AJIC here: ajicjournal.org.



Emerging Infectious Diseases Task Force

The Emerging Infectious Diseases (EID) task force was formed in the summer of 2022 with a purpose to create a “rapid response” process within APIC in order to facilitate a faster response to novel pathogens. The task force, chaired by Rosa Lozano, MPH, CIC, is comprised of liaisons from the education, public policy, and communications committees plus additional subject matter experts (SMEs) to help ensure a well-coordinated response. SMEs represent a wide variety of settings and backgrounds to ensure guidance is relevant and applicable across the many different settings and populations in which our members serve. The vision of the task force is to provide resources that are comprehensive, operational, customizable, and support infection preventionists so they may continue to focus on creating a safer world through the prevention of infection.



Rosa Lozano
MPH, CIC

- Rosa Lozano, MPH, CIC—Task Force Chair
- Margaret Douglas, MPH, RRT, CIC
- Pam Falk, BSMT, MPH, FSHEA, CIC
- Jill Holdsworth, MS, CIC, FAPIC, NREMT, CRCST
- Tawanna McInnis-Cole, MS, BSN, RN, CIC
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Federal Regulatory Update: COVID-19 and Beyond

BY LISA TOMLINSON, NANCY HAILPERN, AND RICHARD CAPPARELL



During the COVID-19 Public Health Emergency (PHE), federal government agencies worked to keep up with evolving science and real-world experience to provide guidance and regulation. Let's take a look back at the changes over the last few years.

Centers for Disease Control and Prevention (CDC)

As the nation's leading science-based, data-driven public health agency, the Centers for Disease Control and Prevention (CDC) has been a key player in establishing and updating guidance for healthcare facilities during the COVID-19 pandemic. CDC maintains the National Healthcare Safety Network (NHSN), the primary data collection site from healthcare facilities, state and local health departments, local and regional laboratories, and public health agencies around the world. Most government agencies rely on CDC guidance to inform their regulations, standards, and guidelines. Since SARS-CoV-2 was a novel virus, there was very little information at first on modes of transmission and no available treatment or tests for the virus. CDC was, therefore, updating guidelines relating to prevention, detection, and treatment of COVID-19 as new information was being discovered, sometimes on a daily basis. This often caused a great deal of confusion as healthcare providers struggled to keep up with CDC guidance while also trying to keep up with massive patient surges, high death rates, and high rates of transmission to healthcare workers. In the face of massive supply and personnel shortages, CDC was also developing recommendations for reuse or extended use of disposable PPE and other temporary controls for emergent situations.

As part of CDC, the National Institute for Occupational Safety and Health (NIOSH) provided guidance to address research and practice gaps on personal protective equipment (PPE). During the extreme pandemic-related supply shortages, NIOSH provided recommendations for alternatives to medical grade PPE for use by healthcare

personnel (HCP), patients, and the public. NIOSH also provided fast-track review and approval of domestic and foreign-made filtering facepiece respirators (FFRs) such as KN95s from China and KF94s from South Korea. NIOSH also kept healthcare providers and the public informed about fraudulent PPE that was flooding the market.

Centers for Medicare & Medicaid Services (CMS)

As the largest funder of healthcare in the U.S., the Centers for Medicare & Medicaid Services (CMS) can enforce implementation of its regulations through payment penalties and incentives. CMS regulations generally seek to comply with evidence-based guidance from CDC, although during the PHE, CDC updated guidance far faster than CMS or other regulatory agencies could keep up with. In the first year of the pandemic alone, CMS issued more than 35 guidance documents relating to COVID-19 care in healthcare facilities.

Medicare Payment Programs

Among the first actions taken by CMS at the start of the PHE was to provide enforcement flexibility to healthcare facilities, including limiting hospital surveys to prioritize infection control and immediate jeopardy complaints and limiting annual updates to quality reporting, value-based purchasing (VBP), and hospital-acquired condition (HAC) reduction (HACRP) programs. CMS also made NHSN healthcare-associated infection (HAI) reporting requirements voluntary for Q4 2019 and Q1 and Q2 2020 to reduce administrative burden on healthcare facilities. To avoid penalizing Medicare-funded facilities due to unreliable pandemic-era data, CMS implemented a measure suppression policy that has now been continued through FY 2023 for payment determinations in the VBP and HACRP programs. This policy allowed CMS to not use data for certain measures to determine Medicare payments; however, the data were still provided in confidential reports to hospitals and publicly reported on the Medicare *Care Compare* website.

See APIC's comments to CMS in 2021 supporting the Measure Suppression policy https://apic.org/wp-content/uploads/2021/06/IPPS-FY2022_FINAL_6-22-21.pdf



Long-Term Care

Nursing home residents and staff were among the hardest hit by the COVID-19 pandemic with infection and death rates far above those for the population at large. During the pandemic, CMS issued and frequently revised regulations:

- requiring nursing homes to report COVID-19 suspected and confirmed cases among residents and staff to the NHSN Long-Term Care Facility COVID-19 Module, as well as to residents, their representatives and families
- providing guidance on visitation to nursing homes
- providing guidance on COVID-19 testing, masking, and social distancing
- establishing COVID-19 vaccination policies for staff, residents, and visitors
- providing toolkits for states to mitigate COVID-19 in nursing homes, and
- many other issues.

In addition, the Biden administration issued a policy statement on Improving Nursing Home Safety and Quality to create a plan to ensure sufficient staffing, training, accountability, and transparency in nursing homes.

Food and Drug Administration (FDA)

FDA provides approval or authorization for drugs and medical devices. In emergent situations, such as when the Secretary of Health and Human Services has issued a public health emergency, the FDA may issue "emergency use authorization" (EUA) to get products to the public more quickly when no comparable product is available for the same purpose. The EUA will expire when it is withdrawn by FDA, revised, or circumstances no longer meet the criteria for emergency use.

During the COVID-19 pandemic, FDA has approved or authorized drugs and devices for testing, diagnosis, and treatment of COVID-19, including over 440 tests and sample collection

devices, four monovalent and two bivalent COVID-19 vaccines, and hundreds of ventilators, ventilator accessories, PPE, and other medical devices.

Occupational Safety and Health Administration (OSHA)

Although OSHA has been developing an infectious diseases standard since 2010, the effort appeared to have been stalled. When the COVID-19 pandemic hit in 2020, OSHA's initial responses were to relax fit-testing and inspection requirements to allow healthcare facilities to focus on the immediate patient surge, and to revise and outline existing guidance on preventing COVID transmission. President Biden issued an Executive Order on Protecting Worker Health and Safety on his first day in office, calling on OSHA to consider whether an emergency temporary standard (ETS) was needed. OSHA launched initiatives to prioritize in-site workplace inspections and enforcement on highest-risk employers, and then issued the COVID-19 Healthcare ETS in June 2021 requiring employers to develop and implement workplace safety plans, including guidelines for the use of PPE and the implementation of engineering and administrative controls, cleaning and disinfection, and reporting and recordkeeping. See APIC's comments to OSHA on the COVID-19 Healthcare ETS in 2021.

By definition, an OSHA ETS is not permanent and must be withdrawn or replaced by a permanent standard after six months. Much of OSHA's COVID-19 requirements were based on CDC guidance, and since that guidance was rapidly changing, OSHA decided to focus efforts on creating a permanent standard but was unable to complete the task within the allotted six months. In December 2021, OSHA withdrew all provisions of the COVID-19 healthcare ETS except the reporting and recordkeeping provisions, which were already covered under other OSHA standards. At press time, we are awaiting imminent release of a new OSHA Occupational Exposure to COVID-19 in Healthcare Settings Standard. We also expect to see a proposed rule for the long-awaited Infectious Diseases Standard in Fall 2023. See Testimony of APIC Public Policy Committee Chair Lisa Sturm to OSHA on establishing an Occupational Exposure to COVID-19 in Healthcare Settings permanent standard, April 4, 2022.

COVID-19 Vaccination

Several federal agencies have had a role in approving and promoting COVID-19 vaccination.

FDA

Before new drugs are available to the public, they must first be reviewed and approved by the FDA. Although the drug approval process is rigorous, in the event of a public health emergency, the HHS secretary may allow FDA to grant EUAs to facilitate the availability and use of unapproved medical products or unapproved uses of approved products to diagnose, treat, or prevent serious or life-threatening conditions when no approved alternative exists. The FDA granted EUAs for monovalent vaccines to prevent COVID-19 to four manufacturers—Pfizer-BioNTech, Moderna, Janssen, and Novavax. EUAs were also granted to Pfizer and Moderna for a bivalent COVID-19 booster. Subsequently, full approval was granted for the Pfizer and Moderna monovalent COVID-19 vaccines. When the COVID-19 PHE ends, existing EUAs for COVID-19 products will remain in effect and FDA may continue to issue EUAs when criteria for issuance are met.

CDC

After FDA approves or authorizes a vaccine, CDC reviews all available data, and through the Advisory Committee on Immunization Practices (ACIP), issues a recommendation for use of the vaccine. Both CDC and FDA continue to monitor the vaccines to ensure safety and efficacy of the products and may alter recommendations as new information becomes available.

OSHA

After the first EUAs and CDC recommendations for COVID-19 vaccines were issued, OSHA issued the COVID-19 Vaccination and Testing ETS, which required employers with 100 or more employees to develop, implement, and enforce a mandatory written COVID-19 vaccination policy. The ETS allowed employers to include in their policies an exception allowing non-vaccinated employees to undergo weekly testing and wear a face covering at work. The OSHA Vaccination ETS did not apply to workers in facilities governed by Medicare or Medicaid; those workers were covered under a separate CMS COVID-19 Vaccination rule (see below).

CMS

At the same time that OSHA issued its COVID-19 Vaccination and Testing ETS, CMS issued the Medicare/Medicaid Omnibus

COVID-19 Healthcare Staff Vaccination interim final rule. This rule required all staff of facilities participating in Medicare or Medicaid to be fully vaccinated against COVID-19, and also required facilities to provide accommodations for those with medical or religious exemptions, including testing, physical distancing, and source control. See APIC's comments to CMS on the Omnibus COVID-19 Healthcare Staff Vaccination rule.

CMS also added a new COVID-19 Vaccination Coverage Among Healthcare Personnel measure to the Quality Reporting Programs for most care settings. This measure required facilities to report HCP COVID-19 vaccination to NHSN beginning in October 2021.

U.S. Supreme Court

After some opposition to COVID-19 vaccination mandates from some states and large employers, the U.S. Supreme Court heard two cases—one relating to the OSHA ETS and one relating to the CMS rule. In the case of *National Federation of Independent Business v. OSHA*, the Court ruled that OSHA had exceeded its authority in mandating COVID-19 vaccination because the condition is not exclusively a workplace hazard. Following the ruling, OSHA withdrew the COVID-19 Vaccination and Testing ETS.

In the case of *Biden v. Missouri*, the Court took a different stand. It ruled that, since participation in CMS payment programs is voluntary, CMS has authority to impose vaccination requirements for employees of healthcare facilities participating in these CMS-funded programs like CMS imposes other Conditions of Participation in CMS payment programs.

The COVID-19 pandemic has led to significant new federal regulations and guidelines aimed at preventing the spread of the virus and protecting patients and healthcare workers. Federal agencies and departments such as the CDC, CMS, FDA, and OSHA have been instrumental in establishing and updating these guidelines, and they will likely continue to play an important role in infection control efforts as the pandemic continues. But the pandemic also aimed a spotlight on significant gaps in infection control staffing and emergency preparedness in healthcare facilities. In these areas, APIC expertise is needed more than ever. [P](#)

Lisa Tomlinson, MA, CAE, is APIC vice president, Government Affairs and Practice Guidance; Nancy Hailpern is APIC director, Regulatory Affairs; and Richard Capparell is APIC director, Legislative Affairs.

Addressing Vaccine Hesitancy in Long-term Care Facilities

BY APIC CONSULTING SERVICES

Janina-Marie Tatar,
MBA, CIC, LTC-CIP



Janina-Marie Tatar is an infection preventionist with a background in clinical microbiology and 20 years of experience in hospital and residential healthcare settings. She holds a Master of Business Administration (MBA) and is a candidate for Doctor of Education in Organizational Change and Leadership (EdD). Tatar has earned multiple certifications in infection prevention and control, including the Certification in Infection Prevention and Control (CIC®), and recently the Long-Term Care Certification in Infection Prevention (LTC-CIP). In 2022, she received the APIC Graduate Student Award Scholarship and the APIC Chapter Leader Award.

PS: What prompted you to pursue infection prevention consulting work with APIC Consulting Services?

Tatar: I started independently consulting in 2012. Part of the frustration with consulting is finding consistent work and managing projects as originally defined, without project time and effort expanding

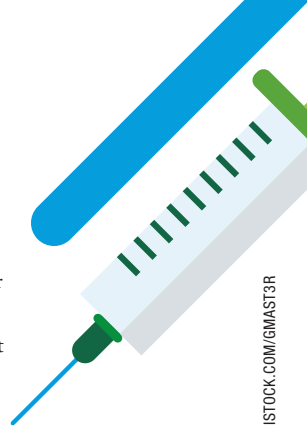
past the original scope of work. With APIC Consulting, they work with the client to develop a streamlined scope of work and contract, including billing and payment collection. Additionally, APIC Consulting allows me to choose the infection prevention and control (IPC) projects that align with my passions to make an impact and what means the most to me.

PS: Can you describe your current work through APIC Consulting?

Tatar: The current consulting project I'm working on is for a Quality Improvement Organization (QIO) client. The QIOs work collaboratively toward state or federal healthcare quality goals to improve patient care. In this case, the consultant works directly with long-term care facilities (LTCFs), stakeholders such as residents and families, and regulatory bodies to improve healthcare quality and increase COVID-19 vaccination rates at LTCFs.

PS: What services did the client seek?

Tatar: The purpose of this project is to determine barriers to vaccination at each LTCF enrolled in the program and address barriers with facility leadership to increase bivalent COVID-19 vaccination rates



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among residents. The client emphasized consultant autonomy regarding solutions to vaccination barriers, with the ultimate project goal to increase resident vaccine compliance and rates.

PS: Can you tell us about the client’s need for IPC consultants to support their vaccination outreach?

Tatar: The client openly shared that their previous work utilizing other healthcare consultants without extensive IPC experience was not successful. I think the lived IPC experiences of a CIC-certified consultant allows for enriched solutions, and that certainly has been the case throughout this project. Most infection preventionist (IP) consultants have lived through the transition from LTCF IPs policing practices and procedures to IPs being viewed as training and educational collaborators. Knowing and emphasizing regulatory standards and guidelines at a facility is not enough. IPs need to know how to effectively communicate with all LTCF team members. The key is to cultivate relationships and build trust among LTCF administrators and IPs.

PS: What are the barriers you see in LTCFs regarding vaccination compliance and rates?

Tatar: I see three prominent issues that become barriers for LTCFs and residents—reporting complexity, vaccine consent, and dedicated/supported facility IPs.

- The first barrier involves changes to National Healthcare Safety Network (NHSN) reporting to reflect the different COVID-19 boosters available. NHSN reporting is not always intuitive, and it can be a new concept for certain administrators. Even when administrators are confident they are not having NHSN reporting issues, I encourage a one-on-one virtual meeting with the IP to review the process. Even though these are LTCFs, boosters are sometimes given prior to admission, and vaccination tracking over time and among facilities is difficult.
- The second barrier is resident and family vaccine consent. I do not think this is a true anti-vaccination issue. I think this

problem arises when people have vaccine information overload.

- The last barrier for vaccination compliance and rates includes the resources and people available to support LTC IPs. Many of these IPs inherited IPC, and the IPC responsibilities were added to their other nursing duties. The pandemic has exacerbated poor support in LTCFs for the IP role. The lack of support for IPs along with their growing workloads results in symptoms of burnout like increased cynicism, exhaustion, and reduced professional efficacy. It is imperative to empower and support this IP role. Even when the administrator wants to be the contact person for the project, I insist on including the IP or securing additional time with the facility IP.

By addressing these barriers with IPC training education, and additional dedicated resources, LTCFs can work toward higher vaccination compliance and rates.

PS: How did you address these barriers?

Tatar: The main framework I use for addressing vaccination barriers is a gap analysis. I first determine the state of the facility’s current vaccination program to highlight the programmatic strengths. After the initial assessment, I work with administrators to identify the other key facility stakeholders of the vaccination program. I clearly state the improvement goal and identify secondary midpoint goals, especially if they have struggled with vaccination compliance in the past.

My strategy is different for a facility that has a high resident COVID-19 primary series compliance versus if the facility has low compliance. Resident movement and length of stay can also impact compliance and the best course of action. At the most basic level, I consider their current state of compliance, identify their ultimate compliance goal, and work backward, asking “who, what, where, when, why and how” or “the 5Ws and 1H.” I use simple Plan-Do-Study-Act (PDSA) models with minimum monthly progress tracking, to help LTCFs track interventions and progress toward the compliance goal. The IP can easily report

the PDSA progress at their Quality Assurance and Performance Improvement (QAPI) meetings.

PS: As an IP professional, how do you address misinformation and vaccine hesitancy?

Tatar: The most critical piece would be dialogue with whoever has the misinformation or is dealing with vaccine hesitancy. My combined knowledge of organizational change theory and behavioral health experience provides me a unique perspective on synthesizing solutions.

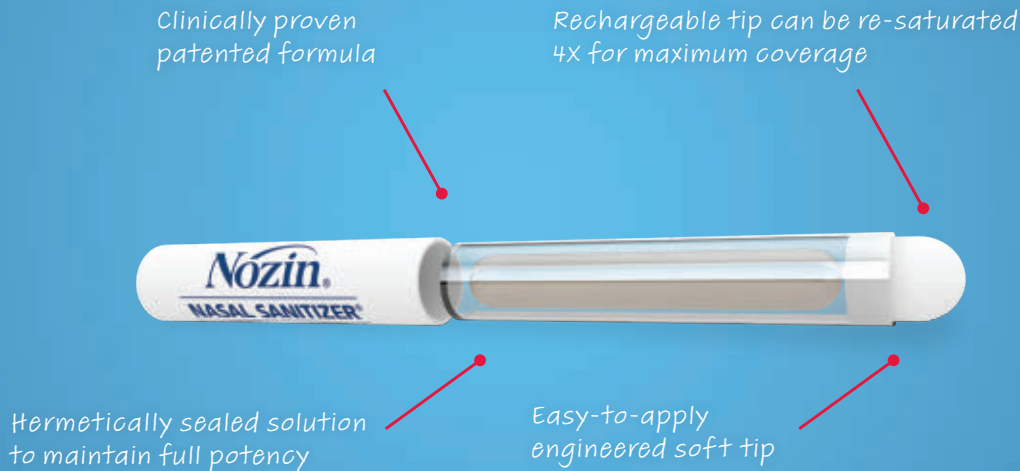
I use motivational interviewing for person-level interactions. Whether talking to residents at an LTCF or a community member, respecting a person’s decision is essential. We are not here to change someone’s core beliefs, but to better understand why someone who has previously received vaccinations has not committed to a particular vaccination or booster. Often, a person ambivalent about moving forward with vaccination will choose vaccination if allowed to work through what has been holding them back. Too often in healthcare, once a patient refuses a vaccination, the patient is labeled “anti-vax” or “not interested in vaccination”—but motivation changes and knowledge increases over time. We never disregard a safety initiative based on one refusal at a point in time. There is room for discussion and information sharing, so each patient can make their best decision.

PS: Can you give us an example of an IPC win for this project?

Tatar: As the project’s definition of what constitutes an up-to-date resident evolved, I was able to help build a report view for the client, so all team members could quickly reference a dashboard featuring the facility’s progress towards compliance goals. Never underestimate your skillset. Clients are pleasantly surprised by what IPs bring to the table. **PS**

If you’re interested in becoming a consultant or would like more information about services, contact APIC Consulting Services at info@apicconsulting.com.

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Conversation with an IP:

Luz Caicedo, MPH, CPH, CIC, CRCST, VA-BC



Luz Caicedo, MPH, CPH, CIC, CRCST, VA-BC

PHOTO CREDIT: LUZ CAICEDO

Luz Caicedo, MPH, CPH, CIC, CRCST, VA-BC, has worked in the field of infection prevention for seven years, and is currently the President of the APIC Central Florida Chapter. She earned her Bachelor of Public Health, and Master of Public Health with a concentration in Global Communicable Diseases from the University of South Florida. In June 2022, she was recognized as an APIC Champion for her dedication to helping others pursue their CIC. She is currently the Infection Prevention Manager at AdventHealth Celebration and is dedicated to creating career ladders and building a multidisciplinary team. Her main areas of interest are public health, vascular access, education, and sterile processing.

Prevention Strategist: What inspired you to become an infection preventionist?

LC: I first became interested in the field as a graduate student, while taking an infection prevention class and working as a medical scribe in the emergency department (ED). This class made me hyper aware of hand hygiene, and I started to encourage our ED providers to clean their hands when I was their scribe. I fell in love with infection prevention after becoming a Healthcare-associated Infections Epidemiologist and working my very first outbreak of a multidrug-resistant organism with my colleague Dr. Danielle Rankin. During this outbreak we both got the opportunity to work alongside the CDC, and I knew that I could see myself doing this work for a very long time.

PS: What were some of your challenges when you first entered the field?

LC: This field requires for infection preventionists (IP) to be knowledgeable in a variety of areas such as: infectious diseases, epidemiology, vascular access, sterile processing, construction, etc. The list is very extensive, and the most challenging part of the role was learning that it was going to take time to build expertise and knowledge in all of these areas. To the new IPs, it's okay to not know the answer to every question. Be kind to yourself, and always remember that Rome wasn't built in a day.

PS: What has helped you most as you have progressed in your role as an IP?

LC: Mentorship has been my biggest blessing in this role. I have had the privilege of meeting dedicated and talented professionals throughout the past couple of years. Whenever I feel stuck, or unsure on how to tackle a problem, I have a strong network of professional mentors that I can always lean on for guidance.

PS: How has your background helped you in the IPC profession?

LC: My MPH has allowed me to rely on my training and education to tackle both clinical and non-clinical problems within the acute care setting. I rely on data and research to guide many of the initiatives at our hospital. I work alongside our clinicians to support the implementation of infection prevention strategies. Our most recent success was receiving approval to trial antimicrobial PICC lines in our hospital.


PS: Why is obtaining (or maintaining) the CIC credential important to you?

LC: Preparing for my initial CIC was truly a labor of love and dedication. Studying for this exam allowed me to explore key areas of infection prevention that were new to me as an epidemiologist working in public health. It was a challenging exam, but the CIC is truly a testament to an individual's commitment to infection prevention, patient safety, and public health.

PS: What advice do you have for others who are new to the field or considering the field of infection prevention and control?

LC: If you have even the slightest interest in this field, please reach out! IPs are extremely passionate about infection prevention and enjoy sharing this career with others. Reach out to your local hospital and ask to shadow for a day. Consider joining your local APIC chapter and attending meetings to network. This is an excellent career, and sometimes you just need someone to give you a chance.

PS: What do you love the most about being an IP?

LC: The first thing that brings me joy at work is that I can always count on my day to bring me a new piece of information, or a new challenge to tackle. The second thing is that I truly love being a preceptor for MPH students. I have had the opportunity to have several interns in my department, and the majority of them are now IPs. Lastly, I love the amazing team that I work with at AdventHealth Celebration. They truly make all of the effort worth it. 

Focus on long-term care and behavioral health outbreaks

Identify the Pathogen!

BY STEVEN J. SCHWEON

Hospital outbreaks are reported more often in the medical literature than occurrences in the long-term care (LTC) or behavioral health setting. By studying and learning from outbreaks in the LTC/behavioral health setting, infection preventionists (IPs) can glean additional knowledge and apply this information to hopefully prevent future infections and infection clusters in their facilities. This quarterly column helps the IP heighten awareness of appropriate interventions to prevent outbreaks.

A recent respiratory outbreak report involving seven disabled children occurred in a Ukrainian LTC pediatric facility, resulting in all the ailing individuals being hospitalized at the “Lviv Regional Infectious Disease Clinical Hospital” for additional medical support.^{1,2,3,4} This facility houses people who have been disabled since childhood.⁴

Based upon your clinical acumen, you suspect the pathogen to be:

- a. Norovirus
- b. Usutu virus
- c. *Corynebacterium diphtheriae*
- d. *Afipia felis*

The children were diagnosed with diphtheria, a vaccine-preventable disease, caused by the bacterium *Corynebacterium diphtheriae*. Diphtheria has been characterized as “The Strangling Angel of Children.”⁵

Hippocrates first described diphtheria in the fifth century BCE, with epidemics noted in the sixth century.⁴ Diphtheria is derived from the Greek “diphthera,” meaning “leather

hide.”⁶ This references the parchmentlike membrane that forms in the throat and is characteristic of the disease.⁶

The exotoxin-forming, Gram-positive rod bacterium, *Corynebacterium diphtheriae*, is the primary pathogen source for diphtheria. Non-toxic *C. diphtheriae* may also cause nasopharyngeal infection, endocarditis, and septic arthritis.⁷ Rarely, other *Corynebacterium species* may also cause diphtheria.⁷

Corynebacterium is derived from the Greek words “koryne” meaning club and “bacterion,” meaning little rod.⁸

The APIC “Ready Reference for Microbes” notes bacterial toxins can greatly increase the virulence of pathogens.⁹ Diphtheria toxin is toxic to myocardial cells, the respiratory system, nerves, and kidneys.

The virus first appeared in the United States in 1858. During this time, one physician felt children and weakly adults had less of an ability to becoming infected due to “defective exercise, improper diet, dark

rooms, damp houses, imperfect ventilation, and poisonous emanations from decomposing filth in privies, cesspools, sewer pipes, etc.”¹⁰

Diphtheria occurs worldwide in countries with suboptimal vaccination programs but is rare in industrialized countries, including the United States due to universal childhood vaccination.¹¹ In the United States, there were two diphtheria cases reported during 2019.¹²

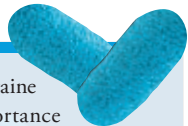
The New York Department of Health¹² notes, “Most of the infrequent cases of diphtheria in the U.S. are among unvaccinated or inadequately vaccinated persons, particularly those who travel to areas where diphtheria is common and those who come into close contact with travelers from such areas.”

Global outbreaks have been reported, with 10,107 cases reported in 2020.¹¹ However, under-reporting of cases is suspected.¹⁴ Outbreaks have occurred in destabilized parts of the world due to population migration and political strife.¹⁵

Transmission occurs most often through person-to-person contact through respiratory droplets via sneezing or coughing.^{16,17}

Cutaneous transmission occurs by exposure to an infected skin lesion and contact with contaminated items, e.g., clothing that is soiled with discharges from the skin lesions.¹⁶

Diphtheria’s incubation period occurs between two to five days after exposure, with



The Russian invasion of Ukraine continues to stress the importance of ensuring vaccination programs continue, both within the country and refugee centers, against vaccine-preventable diseases.

This carries a greater urgency during a pandemic (<https://www.nature.com/articles/s41467-022-31441-x>) where healthcare is displaced and vaccine hesitancy is expressed (<https://www.who.int/news/item/15-07-2022-covid-19-pandemic-fuels-largest-continued-backslide-in-vaccinations-in-three-decades>). Increased diphtheria cases have been reported in European migrant centers (<https://www.ecdc.europa.eu/en/news-events/increased-diphtheria-cases-among-migrants-europe>).

Upon arriving in the United States (<https://www.cdc.gov/mmwr/volumes/71/ss/ss7102a1.htm>), immigrants undergo a medical evaluation that includes their vaccination history (<https://omb.report/icr/202010-1405-004/doc/105591100>), and documentation of required vaccines, prior to arrival.

Refugees, due to the urgency of their resettlement, are not mandated to receive the required vaccinations for admission to the United States; instead they must provide vaccination documentation as part of their resettlement process. (CDC immigrants <https://www.cdc.gov/mmwr/volumes/71/ss/ss7102a1.htm>).

a range of one to 10 days.¹⁶ Individuals who are either symptomatic or asymptomatic can transmit this pathogen, with asymptomatic carriers causing less infection than symptomatic carriers.¹⁸

During the infection onset, the pharynx and tonsils become infected, with the bacterium secreting a toxin.¹⁶ Signs and symptoms include malaise, sore throat, hoarseness, swollen neck lymph nodes, nasal discharge, anorexia, and low-grade fever.^{16,19}

Within two to three days, a membrane forms, varying in size to covering the tonsils to covering most of the soft palate. Extensive membrane formation, including trachea occlusion, may lead to respiratory obstruction.

The toxin is also absorbed in the bloodstream resulting in myocarditis, polyneuropathies, nephritis, and thrombocytopenia. A non-toxin producing strain can also cause severe complications.

The CDC states²⁰ cutaneous diphtheria may present as a scaling rash or ulcers, with

clearly demarcated edges and membrane. This condition is commonly identified in tropical countries but is rare in the United States and most often occurs in persons with poor hygiene who live in crowded conditions.¹³ Cutaneous diphtheria is more contagious than respiratory diphtheria.¹³ Between one to two percent of cases will result in systemic toxicity.²¹

The presumptive diagnosis is based upon clinical presentation. A culture is obtained from the affected area, e.g., nares, oropharynx, to identify *Corynebacterium diphtheriae*. Additional testing is performed for toxin production confirmation. The Centers for Disease Control and Prevention (CDC) is the only laboratory in the United States that performs confirmation testing.

The CDC has specific specimen collection and transport guidance.²² Treatment is promptly started for suspected diphtheria without waiting for laboratory confirmation to prevent clinical complications and demise.²³ The infection prevention and control department, clinical laboratory, and the local health department should be notified when diphtheria is suspected.

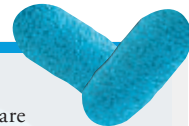
Droplet isolation precautions are used when managing the patient with respiratory diphtheria.²⁰ Precautions are discontinued when the antimicrobial course is completed and there are two consecutive negative cultures obtained 24 hours apart, after antimicrobial cessation.²⁰ Contact isolation precautions are initiated for managing the patient with cutaneous diphtheria.²⁴

Transfer to an acute care medical facility will depend upon the resident's initial and current medical status, with respiratory and other medical support being indicated for clinical demise.

The estimated case fatality ratio, a measure of deaths in proportion to the number of reported diseases, is five percent to 10 percent, with a higher death rate among children younger than five years old and adults older than 40 years old, due to the toxin.^{16,20}

The recommended antimicrobial medications for treatment are erythromycin and penicillin.²⁰ Antimicrobial therapy is also administered to eradicate *C. diphtheriae* carriage, reduce the transmission risk to others, and stop additional diphtheria toxin production.²⁵

Diphtheria antitoxin (DAT), produced in horses, is used for the treatment of respiratory diphtheria, and is administered to neutralize circulating toxin and prevent disease progression.¹⁶ DAT is available from the CDC



Prevention of transmission of *C. diphtheriae* in healthcare settings involves:

1. encouraging vaccination of HCP against diphtheria in compliance with routine adult vaccine schedules^{10,11};
2. in addition to using Standard Precautions, placing patients with known or suspected respiratory diphtheria on Droplet Precautions and placing patients with known or suspected cutaneous diphtheria on Contact Precautions¹²;
3. rapidly diagnosing and treating patients with clinical infection;
4. administering postexposure prophylaxis (PEP) to persons exposed to diphtheria; and
5. excluding potentially infectious HCP from work.

Source: <https://www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/selected-infections/diphtheria.html>.

under an Investigational New Drug (IND) protocol.²⁵ Before administration, the patient should be tested for sensitivity to horse serum and desensitized if needed.²⁶

Routine facility cleaning and disinfection policies with an EPA-registered hospital-grade disinfectant should be performed at least daily. Check with the disinfectant manufacturer to ensure product efficacy against the diphtheria bacterium.

Diphtheria is a nationally notifiable reportable disease.²⁷ The local health department should be notified by both the clinical laboratory and the infection prevention and control department to ensure complete communication.

It's important for the health department to launch a contact investigation and identify individuals, obtain cultures, and provide antimicrobial prophylaxis, using the CDC diphtheria case definition, who may have been exposed to the patient with diphtheria.²⁷

Using the CDC guidance,²⁸ diphtheria toxoid booster (with either tetanus-diphtheria (Td) vaccine or tetanus, diphtheria, and acellular (Tdap) vaccine is offered to induce antibodies in close contacts that are not up to date with their diphtheria and pertussis vaccinations. Vaccination immunity decreases over time.¹⁴ Additionally, diphtheria disease does not always induce immunity.²⁵

Of interest, Ukraine had low childhood vaccination adherence prior to the war; concern has been expressed that this population remains highly susceptible

to vaccine-preventable diseases such as diphtheria, as the war ensues.²⁹ Disinfection was carried at the boarding school, including personal belongings.² An epidemiological investigation was initiated. Samples were collected from all contacts for bacteriological analysis. 106 pupils and employees were vaccinated with the Tdap vaccine.³ **R**

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TAKE-HOME MESSAGES

1. When identifying vaccines, upper-case letters indicate the vaccine has the full-strength amount of vaccine component. The lower-case letters indicate the vaccines use smaller amounts.¹⁴
2. Toxoid vaccines, a weakened, inactivated form of the toxin, alerts the body to produce antibodies, called antitoxins, against the toxin. The vaccine may include an adjuvant and other ingredients.
3. The most recent child, adolescent, and adult immunization schedules will provide the most current vaccination recommendations for residents and staff.^{30,31} The DTaP “Vaccine Information Statement” (VIS) provides detailed information about diphtheria and the vaccine, and with a Ukrainian-language VIS being available.^{32,33} Encourage vaccination as indicated.
4. Obtaining a vaccination and overseas travel history will assist with the diphtheria diagnosis and identifying vaccination opportunities.
5. The CDC³⁴ notes travelers who are not up to date with their diphtheria vaccination and are going to Asia, the South Pacific, Middle East, and Eastern Europe can become infected.
6. According to the CDC³⁵, more than 1 billion people globally are immigrants, refugees, and migrants. Facilities may encounter residents and staff, who met healthcare disparities during their lifetime and may not be up to date with recommended vaccinations, including diphtheria.
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Steven J. Schweon, RN, MPH, MSN, CIC, LTC-CIP, CPHQ, FSHEA, FAPIC, is an infection prevention consultant with a specialized interest in acute care/long-term care/behavioral health/ambulatory care infection prevention challenges, including outbreaks.



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DEI at APIC: Many Voices. One Purpose.

In 2021, APIC committed to a comprehensive, holistic Diversity, Equity, and Inclusion (DEI) focus. This is a multi-year engagement to incorporate DEI into our collective work. Following months of effort by various APIC stakeholders, we recently finalized the first component of this initiative: our DEI vision, mission, values, and behaviors. We are grateful to all who contributed to this initiative, including the APIC board of directors, DEI task force, Health Equity committee, APIC chapter leaders, our members, and our staff. We hope you will join us in helping to advance DEI at APIC. Visit our website <https://apic.org/diversity-equity-and-inclusion-at-apic/> and listen in to our webinars (see text box) to learn more.

LEARN MORE

Two-part webinar series with APIC leaders and Suri Surinder, DEI Lead at Perspectives (APIC's DEI consultant):

- **Update on APIC's New DE&I Initiative, Part 1** provides an overview of DEI. Mr. Surinder shares examples and thought-provoking questions to explain the concepts and establish a shared vocabulary. Registration link: <https://secure.apic.org/WEB/ItemDetail?iProductCode=WB-230323>
- **Update on APIC's New DEI Initiative, Part 2** presents APIC's new DEI statement which includes not only a vision for DEI at APIC, but also the values and behaviors that will demonstrate our organization-wide commitment to this important work. Registration link: <https://secure.apic.org/WEB/ItemDetail?iProductCode=WB-230330>

Diversity, Equity, and Inclusion at APIC

Many Voices. One Purpose.

We recognize and embrace everyone's unique strengths and differences to globally elevate the science, practice, and profession of infection prevention and control, and every individual's role in it.

We are committed to act intentionally, impartially, and transparently towards all our stakeholders. We provide a safe, empathetic, and non-judgmental environment. Fair representation, accountability, and elimination of barriers matter to us.

We want you to feel seen, heard, valued, and respected at APIC. You belong here.



VALUES

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Proactive & Transformational Leadership



Culturally Intelligent Advocacy



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Intentional Collaboration & Engagement



BEHAVIORS

- We exhibit consistency in our thoughts, words, and actions.
- We recognize, celebrate, and leverage our differences.

- We do what's right, even when no one is looking & lead by example.
- We engage all global stakeholders in going further and faster towards creating a safer world.

- We meet people where they are and treat them the way they want to be treated.
- We create accessible pathways of success for the community that we support.

- We celebrate wins and communicate with confidence, humility, and cultural competency.
- We focus on iterative improvement in DEI and are lifelong learners.

- We establish effective work expectations and hold ourselves accountable to improve interpersonal communication and collaboration.
- We create a culture of engagement, involvement, and intentionality.

KEYNOTE SPEAKERS AT 2023 APIC ANNUAL CONFERENCE AND EXPOSITION

Read on to learn who our Keynote Speakers will be this year at annual conference, and what you can expect to learn from their sessions.



**Lisa Bodell, Founder and CEO, FutureThink;
Author of *Kill the Company***

FutureThink CEO Lisa Bodell ranks among the Top 50 Speakers Worldwide (<https://members.real-leaders.com/2022-top-50-keynote-speakers/>) and is the best-selling author of *Kill the Company* and *Why Simple Wins*. She's a global expert on simplification and innovation who inspires audiences to stop their old ways of working so they can do more work that truly matters.

A thought leader and serial entrepreneur, Bodell's transformational message has inspired executives at top-ranked organizations such as Google, Novartis, Citigroup, LinkedIn, and CVS/Aetna. Her provocative yet practical approach enables leaders and their teams to eliminate the unnecessary complexity and time sucks that hold them back and make simplicity their competitive advantage.

See her speak at "Curiosity As Your Next Competitive Advantage," Wednesday, June 28, at 8:30 am, in Orlando, Florida!

Q&A with: Lisa Bodell

Prevention Strategist: How can simplification specifically apply to healthcare professionals?

Lisa Bodell: Healthcare is incredibly complex. Extensive regulations, paperwork, and matrixed org structures are just a few of the factors that healthcare employees deal with on a daily basis. But people in

healthcare want to spend their time saving lives and improving patient outcomes—*not* creating reports, drowning in data, and sitting in endless meetings.

The purpose of simplification is to free up your time to do more things that matter. Learning how to eliminate low-value tasks allows you to focus on important work—the work you were hired to do in the first place.

From Novartis and Pfizer to Scripps and BCBS, leaders in the healthcare space are seeing simplification as a competitive advantage. By reducing meetings, taking steps out of processes, and rewarding people for eliminating unnecessary work, they are saving millions of dollars while increasing efficiency. Even more importantly, they are spending more time on innovation, focusing more on patients, and improving the well-being of their employees (which results in increased employee retention).

PS: What's your advice for a stronger work-life balance?

LB: Ask yourself this question: are you spending your time on the things that matter? Most of us don't spend our time with intention—we give it away without thinking, or, we say yes to things out of obligation. Think about it: most days you just get booked up with meetings and calls, and at the end of the day probably haven't accomplished what you want to. In fact, for many of us our greatest daily achievement is

that we've executed our calendar. That's not very valuable.

Work-life balance means putting boundaries on our time. To do that, we need to start saying YES with intention and NO with purpose. What does that mean? First, define what is meaningful/valuable to you—both at work and at home. This will tell you where you want to spend your time.

Next, make a list of how you currently *spend* your time. Look at a typical week or month and jot things down off your calendar. When you're done, circle the things on your list that align with your definition of meaningful and valuable.

For most people, they discover how little time they spend on the things that really matter to them. That's a red flag that you need to start spending your time with more intention. Before committing to something ask yourself: is this a meaningful or valuable use of my time? If the answer is YES—commit to it. If the answer is NO—you can learn how to say no (nicely) and put boundaries on your time. If the answer is 'MAYBE' or it's something you feel obligated to do, consider the YES, IF strategy. This puts the ownness back on the asker by making them part of the trade-off. For example, you'll say YES, IF...*you can attend the meeting just for an hour.* Or, YES, IF...*you can put something else on the back burner to make this a priority.* Or YES, IF...*they'll take one of your carpool shifts next week if you do theirs this week.*

PS: What does it mean to “simplify” your routine?

LB: Simplification is about useful subtraction. It starts when we begin challenging our assumptions around how we always do things, such as, a process, a report, a habit or ‘way’ of doing something. To simplify part of your routine at work, remember this acronym: E-O-S. It stands for Eliminate, Outsource, Streamline. As in, what can I *eliminate* from this and would never miss? What can I *outsource* to someone else who is already doing something similar? Finally, what steps can I *streamline* or minimize to make the outcome I want happen faster?

PS: In your opinion, what are some of the most overlooked, but destructive, habits and time sucks in a person’s work style?

LB: One bad habit is not setting boundaries around our time. To simplify, we need to be more intentional with how we spend our time and why. An important step in doing that is to look at our calendars and understand where we are really spending our time, and where we feel it’s being wasted—and take steps to change that.

Another time-sucking habit is context switching. It’s very difficult to get anything strategic or important done if you’re continually interrupted, or, if we only have

small pockets of sporadic time to focus. One thing to try is to block time (even a half-day), for deep work. This is time you’ll dedicate to strategic thinking, complex tasks, or things that are better accomplished when done all at once.

PS: How did you discover the benefits of simplification?

LB: My company, FutureThink, was working extensively with large organizations to help them innovate. These companies had incredibly smart people, big brand names, large budgets, and a strategic focus on innovation. Yet, their efforts kept stalling. Why? When I asked people about this, I discovered that it wasn’t because they didn’t have innovative ideas or that they didn’t know *how* to innovate—it was that they *couldn’t find the time*. They were drowning in ‘the work of work’—meetings, emails, reports, putting out fires, etc.

That’s when I realized that innovation doesn’t start with an idea. It starts with the time to think. We’re so busy doing that we don’t have time for focused thinking anymore. Simplifying was the key to unlocking time for valuable work. Shifting corporate cultures to value meaningful work vs. just rewarding people for ‘getting more things done’ allowed them to see how much time was being wasted on

unnecessary things. For many companies, creating simplification efforts has literally transformed their orgs to not just be more efficient, but to be more innovative and successful.

PS: What can the audience expect to learn and take away from your talk?

LB: Audiences will feel inspired and empowered to stop wasting time on unnecessary, low-value tasks and discover simple techniques to create a corporate culture when valuable, productive work is the norm. Simplification is a critical component to innovation and a strategic advantage that needs to be embraced. I’m looking forward to sharing some incredible stories of how others have hacked their work, eliminated time sucks and killed stupid rules that were holding them back.

PS: What further reading do you recommend for someone who wants to simplify their lifestyle?

LB: My *Forbes* column on simplification and innovation is the best place to start—as is my TED talk! I also encourage people to check out *Atomic Habits* by James Clear and *Essentialism* by Greg McKeown. Both offer different perspectives on creating habits that help you do more of what matters to you.



Peter Hotez, MD, PhD, Dean of the National School of Tropical Medicine and Professor of Pediatrics and Molecular Virology & Microbiology at Baylor College of Medicine

Hotez is Dean of the National School of Tropical Medicine, Professor of Pediatrics, and Professor of Molecular Virology and Microbiology at Baylor College of Medicine. He is also the Director of the Texas Children’s Center for Vaccine Development and Texas Children’s Hospital Endowed Chair of

Tropical Pediatrics. Additionally, Hotez is University Professor at Baylor University and a Fellow in Disease and Poverty at the James A Baker III Institute for Public Policy. As an internationally recognized physician-scientist in tropical diseases and vaccine development, he is called upon frequently to testify before Congress. In 2017, he was named by *Fortune* magazine

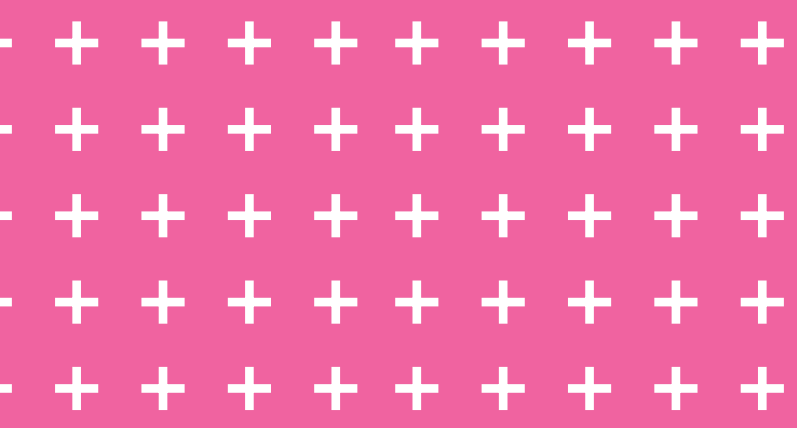
as one of the 34 most influential people in healthcare. Hotez received the Sackler Award in Sustained Leadership from Research!America. He was also the recipient of APIC’s 2022 Distinguished Scientist Award (<https://apic.org/About-APIC/Awards/Distinguished-Awards/Distinguished-Scientist/>).

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AJIC Author Interview

BY PATRICIA STONE



GEETA SOOD

PHOTO CREDIT: GEETA SOOD

A *JIC* Editor in Chief Patricia Stone, PhD, RN, FAAN, interviewed Geeta Sood, MD, ScM, one of the authors of the *AJIC* article “*Clostridioides difficile* infection (CDI) in a previous room occupant predicts CDI in subsequent room occupants across different hospital settings,” Sood G, Truelove S, Dougherty G. *AJIC*. <https://doi.org/10.1016/j.ajic.2022.02.006>.

Sood is an Assistant Professor of Medicine at Johns Hopkins University and Hospital Epidemiologist at Johns Hopkins Bayview Medical Center. She was recruited to Johns Hopkins University in 2011, and she has been the Hospital Epidemiologist at Johns Hopkins Bayview Medical Center, where she led several successful process improvement interventions particularly in the burn intensive care unit for which she won the Armstrong Clinical Excellence Award in Patient Safety in 2015. She is a member of the Maryland Healthcare-associated Infections Advisory Board, the Health Service Cost Service Performance Measurement Workgroup, co-chair for the Patient Safety Committee at the National Quality Forum, and chair for the Society for Healthcare Epidemiology of America Quality Metrics Task force. Her research interests include using big data and machine learning algorithms to predict and ultimately mitigate the risk for developing healthcare-associated infections. She is also working as a medical consultant at the Rhode Island Department of Health.

Prevention Strategist: What challenge were you setting out to address when you started this type of work?

Geeta Sood: Like many of us, we have struggled with reducing our rates of *Clostridioides difficile* infection at our hospital. Since 2015 and even earlier, our rates of *C. difficile* have not changed significantly despite a focus on personal protective equipment, diagnostic stewardship, and basic infection control practices. This has led us to explore other risk factors for infection.

PS: Why is your area of focus important (or relevant) for the infection preventionist and other healthcare workers?

GS: Infection preventionists and healthcare workers are always thinking about ways to reduce or eliminate infections that occur in patients under our care. Over the last decade, the role of the hospital environment has emerged as an important contributor to healthcare-associated infections. As we understand more about how these risks manifest in hospital rooms and even hospital sinks and floors, we can find better ways to prevent infections in our vulnerable patients.

PS: What is your favorite aspect of your work?

GS: Infection prevention is such an exciting field. There are so many opportunities to figure out what may increase infections and to partner with many different services to come up with creative solutions. We get to be CSI agents working with so many different groups to protect our patients. What could be more fun than that?

PS: What is a problem that you solved during your most recent project?

GS: Oh gosh, so many problems and not always good solutions! We have a burn unit in our medical center, and unfortunately we see a lot of complications in this very vulnerable group of patients. We have a terrific partnership with our burn director, and together we faced many challenges including MRSA bacteremia, a fungal outbreak a CRAB outbreak, and many more. Recently we had a patient with candida auris in the unit, and luckily, much to our relief, we have not seen any forward transmission from that patient.

PS: How do your results compare with others in the area? How much consistency is there generally in this area?

GS: The results of our project are similar to what others have found in the role of the environment in *C. difficile* infections. What was interesting in our study was that these findings were across five hospitals and that the impact of exposure to a contaminated room persisted for a year! The consistency of the importance of the environment and the time frame of impact has implications on where may want to focus our prevention efforts and the duration of impact is an important reminder that the consequences of a hospital exposure may persist well beyond what we see within the walls of our hospital.

PS: Is there controversy in this area?

GS: While there isn't a lot of controversy in this area, there are still a lot of unknowns. How do we best find the hidden sources of microorganisms in hospital settings, and what are the best ways to prevent them for colonizing our patients? We are learning more and more about cleaning agents, how to mitigate colonization of gram-negative rods in sinks in patient rooms and what are the best standards for air quality for various respiratory infections. It is an exciting time to be in infection prevention.

PS: What are some of the negatives of your work?

GS: It is always disappointing when our best prevention efforts don't work and patients still get sick. We can only do the best we can, and sometimes we can't prevent every infection. Luckily science keeps moving forward and we can keep learning and growing and finding better and more creative solutions.

PS: Briefly, what excites you about your work? Tell me what you like to do when you aren't working.

GS: I think we have a very exciting and very important jobs. We get to solve problems and make a difference in our patients' lives every day. I am an ID physician, and in my clinical work, I love to be able to make my patients' lives better. In infection prevention, we get to make many patients' lives better! In my free time, I love watching mystery movies, traveling, trying new restaurants, and baking (poorly). **RS**

Strategies to recruit and retain IPs: THREE CASE STUDIES

A key goal of APIC’s strategic plan is to build the IPC workforce of the future. One of the ways we are achieving that is by promoting best practices for attracting and retaining IPs. As part of this initiative, we are collecting success stories from various healthcare organizations and sharing them across platforms in hopes of spurring cross-organizational adoption of successful ideas and tactics.

This article includes the experiences of three different organizations. We hope their stories spark your thinking about how to enhance recruiting and retention efforts at your organization. We invite you to share your success story! To set up an interview with our team, please email Bob Hall: BBHall@apic.org.

TUKHS Kansas City Division: Homegrown and Built to Last

BY ELIZABETH GARMAN, MARTHA SAUCHUK, BOB HALL, AND ALEXIS CAHILL

The University of Kansas Health System (TUKHS) Kansas City Division has built a team of 15 infection preventionists (IPs) that withstood the pandemic. What’s equally noteworthy is that over the last six years, only one of their IPs came on board with previous infection prevention and control (IPC) experience; the others were trained onsite, from the ground up.

Tiffany Horsley-Kesinger, BSN, RN, CIC, joined TUKHS KC Division in 2016 as an IP with seven years of previous IPC experience. Since then, every other recruit has joined as a complete newbie. “We have home grown all of our IPs with the exception of me,” says Horsley-Kesinger.

Recruitment success through internship program and strong orientation process

TUKHS KC Division has developed an impressive program to recruit and train new IPs through their IPC internship program. Currently designed for people who already work in-house, participants work three 12-hour shifts in their own department and then get paid as part of the internship for an extra four hours per week of IPC work.

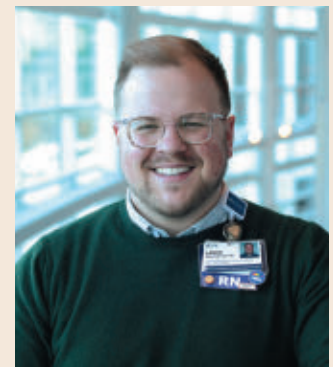
“The internship program has been a game changer for recruitment,” says Lance Williamson, MSN, RN, CIC, IPC nurse supervisor. Two of the last three hires came from the internship program. Williamson and Horsley-Kesinger say they look for ‘personality and passion’ when it comes to new members of the team. Williamson started his career in behavioral health and was recruited to join the IPC team after helping them mitigate a norovirus outbreak on his unit.



The team at TUKHS

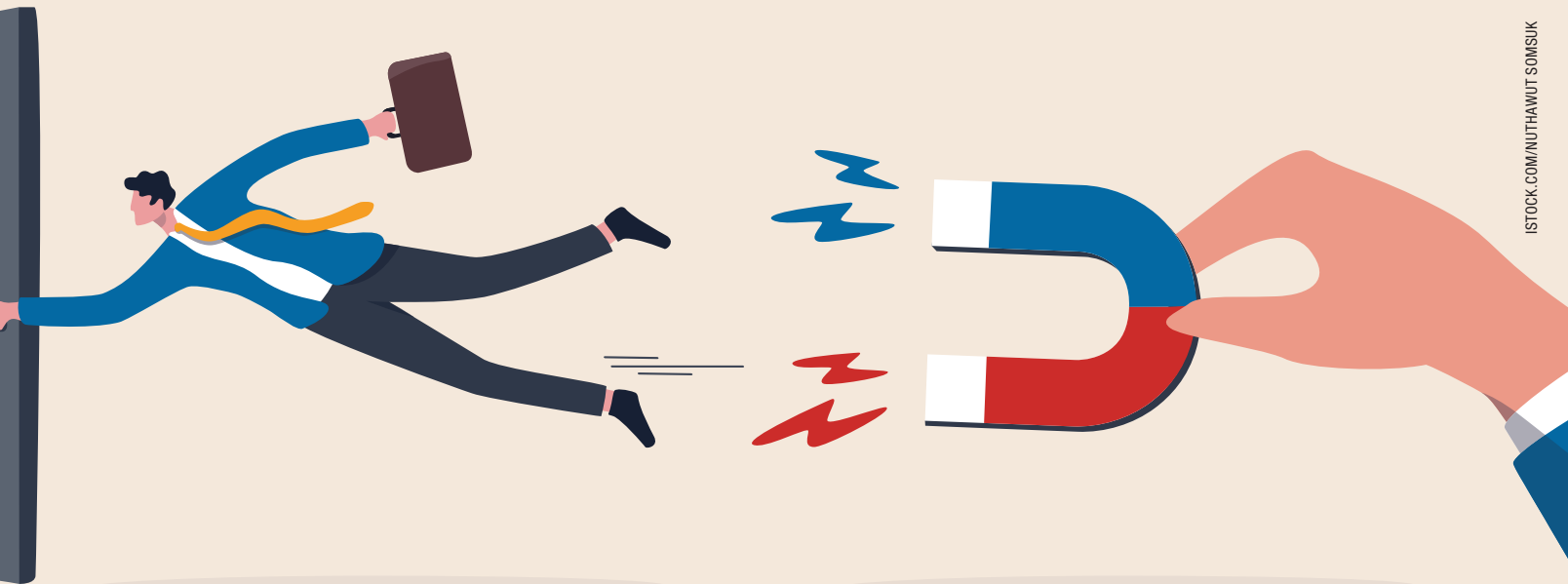


Tiffany Horsley-Kesinger



Lance Williamson

PHOTOS COURTESY OF TIFFANY HORSLEY-KESINGER



“Some applicants perceive IPC as being an easier schedule, a ‘retirement job,’ but we know it can be intense and not for the faint of heart. You have to be *interested* in this science to succeed,” says Horsley-Kesinger. The internship program allows them to get to know potential hires for two to three months and see if they are a good fit.

They also have been intentional in the way they onboard new IPC team members, so they feel well-supported every step of the way. The orientation, which aligns with the APIC Competency Model (<https://apic.org/professional-practice/infection-preventionist-ip-competency-model/>), lasts six months. On-call orientation goes up to two months more. During this time, new IPs do not take on unit responsibilities.

APIC involvement is an expectation right from the start, beginning with participation in APIC trainings their first year. Everyone is encouraged to participate at the chapter level and present at local and national conferences. Horsley-Kesinger notes that many of her colleagues have served in APIC leadership.

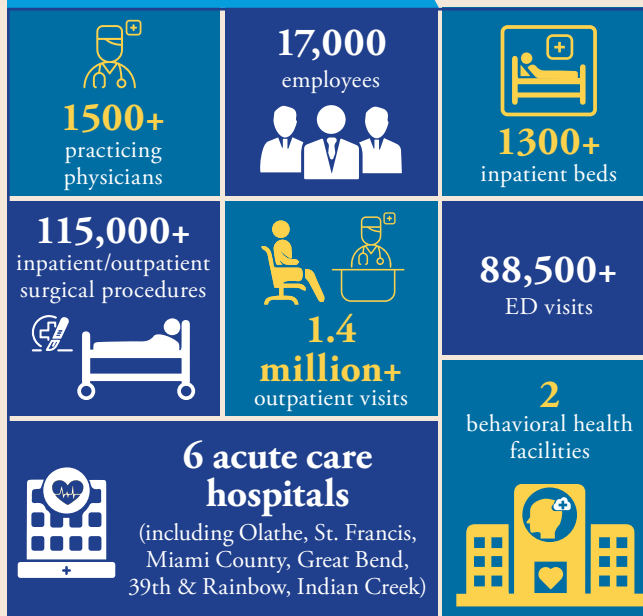
Diverse backgrounds benefit the whole team

TUKHS KC Division works to recruit IPs from a wide variety of backgrounds and is trying to move away from the legacy ‘infection control nurse’ terminology. Two recent hires were non-nurses. One came from a state health department, and the other is currently obtaining her MPH and had interned as a surgical tech. “She knows what it’s like to be in the OR—and that benefits all of us,” says Horsley-Kesinger.

Retention: Flexibility, hands-off style, and diverse opportunities

TUKHS KC Division team experienced low turnover during the pandemic and in fact was able to expand in number, which they attribute to a combination of factors. Telework was a benefit they knew was important to staff and one they have been successful in implementing. Their policy allows 2 days telework per week, with the understanding that team members may need to be onsite when circumstances warrant, like outbreaks, The Joint Commission visits, or other emergencies. Horsley-Kesinger and Williamson agree that the team’s perception of improved work/life balance outweighs any challenges.

TUKHS AT A GLANCE



To overcome the perception that IPs can’t influence virtually, the team tweaked the language used to describe office work from ‘in office’ to ‘onsite’ to more accurately describe the fact that even when IPs are ‘in the office,’ they are often roving from site to site. Desk work is saved for work-from-home days to allow more time for in-person interactions during onsite days. And because their busy nurses often prefer a quick electronic message (their team uses Voalte) vs. an in-person visit for simple IPC interactions, they can save in-person rounding and other ‘positive influencing’ visits for when the IPs are onsite.

Williamson embraces a hands-off leadership style with his team which he believes adds to team morale and aids retention. “My team is autonomous and comprised of advanced professionals who don’t need micromanaging,” he says. “I’m all about ‘Communicate, be available, and do your job.’”

The group uses Teams, Slack, and Voalte to stay connected to each other and readily available to clinical teams needing their guidance. They've increased virtual check-ins and are in constant communication via their Teams chat. At first worried that working from home would disrupt the synergy, Horsley-Kesinger and Williamson agree their team is as connected as ever. "We've built such a supportive environment with this team. It's what keeps me here," says Horsley-Kesinger.

TUKHS KC Division IPC team includes individuals with many different backgrounds and personality types. "You may think that IPs need to be extroverts, but we have room on the team for introverts too," says Horsley-Kesinger. In addition to the system IP who connects the dots with other facilities, the KC Division IP team includes 15 others: a director of IPC, quality, and safety; a medical director (ID physician); an IPC supervisor;

a clinical data specialist; 9 IPs; an IP associate; and an administrative assistant.

Advice

TUKHS KC Division's advice to other groups: "Broaden your horizons on who you expect to be a great IP—people surprise us with what they can do," says Williamson. He added that dropping the RN requirement really boosted interest in positions. He also believes that there are more opportunities than ever to recruit new IPs. "So many people got into public health due to the pandemic and realized they loved it—these new people don't know anything different than 'COVID life' and have a fresh perspective compared to more experienced IPs."



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HCA Healthcare, North Florida Division: Numerous Career Advancement Opportunities and Ample Training

HCA Healthcare, North Florida Division offers many opportunities for career advancement as well as competitive compensation to help recruit and retain IPs. A comprehensive and standardized orientation and 10-week "IP University" is offered to all new IPs across HCA and is designed to help onboard and prepare them for CIC certification.

An Assistant VP for IPC at HCA Healthcare, North Florida Division, Chaz Rhone, MPH, CIC, FAPIC, oversees 15 hospitals and many more freestanding clinics and emergency departments. He is the liaison between the corporate IP team and the IP directors at the hospitals he supervises, supporting his directors' growth as IP leaders.

Recruiting: Personal outreach makes a difference

On the recruitment side, Rhone takes a personal and hands-on approach. An avid user of LinkedIn, Rhone does a lot of personal networking, letting people know how they 'do IP' at HCA. He actively connects with APIC chapters, including the two in his immediate area of Florida. He works closely with Human Resources and likes to conduct the first interview with facility IP director candidates. "You can miss out on good candidates because no one from IPC has met with them," says Rhone.

Rhone has also worked with HR to continue standardizing job descriptions for IPs so there is no confusion about requirements, making it easier to hire people with non-nursing backgrounds.

"I am not a nurse—I am an example of that," says Rhone. He believes that IPs need to take ownership of their departments and work with their HR colleagues to define IPC differently,

pointing out the state of vacancies for nurses, and referencing the research that shows that public health and lab backgrounds overlap with about 80% of the competencies needed for an IP ([https://www.ajicjournal.org/article/S0196-6553\(18\)30782-X/fulltext](https://www.ajicjournal.org/article/S0196-6553(18)30782-X/fulltext)). The new APIC Practice Standards and Career Ladder being created by APIC's Professional Development Committee will help IPs in making the case with their HR departments.

Once a non-nurse is given the opportunity to interview for an IP position, Rhone emphasizes the need for them to do their homework, present themselves well, and ask informed questions. "I coach people to tie their experience to the APIC Competency Model (<https://apic.org/professional-practice/infection-preventionist-ip-competency-model/>) and to make sure they are familiar with the facility's publicly reported HAI data." Rhone tells non-nurse candidates not to give up because eventually the door will open, but they need to be prepared by understanding as much as they can about the role, the facility, and what they bring to the table as a candidate.

On the monetary side, HCA Healthcare, North Florida Division offers compensation consistent with the market and reevaluates salaries on a regular basis to ensure they remain competitive. Says Rhone, "We do not want to lose people over salaries."

Rhone sees the potential to grow recruitment through tie-ins with existing events to recruit nurses, like job fairs, where candidates could be interviewed on the spot. "We do so much to recruit nurses. I'd like to expand that to IPC."



PHOTO CREDIT: CHAZ RHONE

Chaz Rhone



Retention: Employees join (and stay) because of the company’s well-developed career ladder and solid onboarding and training

One of the primary ways HCA Healthcare, North Florida Division retains candidates is also valuable for recruitment: many opportunities and paths for career advancement. Career advancement opportunity is what drew Rhone to HCA and what he says differentiates them from competitors. “Other companies do not have very robust career ladders for IPs, so many jump to HCA to move up,” says Rhone. “I left my last job because there were limited opportunities for advancement.” The division leadership model offered him the opportunity to be a division manager before coming into the Assistant VP role. “I never thought I’d have the title of VP. It really speaks to the value our company places on IPC.”

HCA Healthcare is a highly matrixed company with dual reporting to both quality and medical/IPC. Rhone reports directly to the Division VP of Quality with a dotted line to the Corporate AVP of IP Strategy and Operations. The facility IPs report directly within their facility leadership teams, usually through Quality, with a dotted line to the Division AVP of IPC. He believes that in terms of retention, it helps to report to someone who is a subject matter expert in IPC in addition to Quality.

At HCA Healthcare most surveillance is outsourced to an affiliate of the company, offering this as a career path as well (with its own opportunities for advancement) for those who may not have, or want, hospital IPC experience. Rhone says some

IPs start there and then move to the hospital setting. Because of this surveillance model, IPs on the clinical side have more time to be out on the floors—rounding, coaching, and interacting with frontline providers.

HCA Healthcare also offers “IP University”—a 10-week program available to any IP with 2 years or less experience. The program provides continuing education credit and is



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designed to help IPs prepare for CIC® certification. They have a quarterly all-hands meeting for IPs with presentations from experts and have also standardized the onboarding process so that newly hired IPs complete a 16-week training period to walk them through their orientation, including HCA-specific systems and policies.

Rhone wants new IPs to feel well supported. “I’ve personally lost IPs during the pandemic because they came in and there was no structured orientation—and they felt so unsupported and uncomfortable in the role.” HCA Healthcare has also created a similar onboarding process for executives at Rhone’s level and is currently working on ‘IP University’ for proficient and expert level IPs.

Advice

Rhone’s advice: “Create a career ladder however you do it. At some point people are going to get to a point where they want to move on. At my level—this is usually the top of the ladder without leaving IPC. But if I want to stay in IPC, I can go to the corporate level and work my way up there. We must work to give IPs opportunities for growth and recognition.”

HCA Healthcare, Continental Division: IPC is Built into the Culture and Supported at Every Level

HCA Healthcare, Continental Division integrates infection prevention and control (IPC) into their regular operations, creating an environment for IPs to thrive.

Katie Cary, MT(ASCP), MPH, CIC, Assistant Vice President of Infection Prevention at HCA Continental Division, which covers hospitals in Denver and Wichita, is the longest tenured AVP of Infection Prevention to fill a unique centralized support role for the IPs in her division of hospitals. Says Cary, “I’m more of their ‘person and resource,’ but not their boss. I help provide support and structure and drive improvement.” She adds that having her role at the division level sends a strong signal about the value placed on infection prevention and allows her to bring a higher level of overall vision, development, and strategy to

the infection prevention system within the hospitals. “At HCA, and specifically in our hospitals in Denver and Wichita, IPC is built into the culture.”

Recruiting: Strong support system and team structure

Cary plays an influential role in the hiring process even though new IPs do not report directly to her. Because of this dotted line, she is in a good position to influence change, help hire the right people, and also provide them with support.



Katie Cary

PHOTO CREDIT: KATIE CARY



If anybody needs help, they have resources. If anybody is struggling with an issue, they have resources. If somebody wants to go learn a new service line that's not at their hospital as part of their professional development, I will do my best to make that happen.

"The IP role is hard these days. Having that hands-on support structure and somebody to call on for help is unique to our company," says Cary. "It attracts people."

Cary also believes that the Continental Division's integrated team structure makes them a desirable employer within their markets. "While we are at many different facilities with different challenges, we all have the same goals to work together to keep our patients and colleagues safe," says Cary.

Cary shares that they do not only rely on offering competitive salaries and benefits, but rather the key is the focus on strong teams, even in facilities with a lone IP. "They have their team and support structure here from an infection prevention perspective," explains Cary. At the facility level, Cary says that all IPs have the full support of their medical, nursing, and quality leaders.

Retention: Putting support first

One of the primary ways the Continental Division retains IPs is by providing resources for overcoming challenges and offering professional development across their network. "If anybody needs help, they have resources. If anybody is struggling with an issue, they have resources. If somebody wants to go learn a new service line that's not at their hospital as part of their professional development, I will do my best to make that happen," says Cary. HCA also has an "IP University" that is offered to all new IPs in HCA to assist with onboarding and professional development.

The Continental Division also engages their network to ensure that IPs can maintain a healthy work-life balance. A float IP is available in-person or remote for additional coverage. "I have a float infection preventionist that comes out of the quality cost center," said Cary. "If I have a maternity leave, I can send our float IP over to help support that team. If somebody has an unexpected leave, the float can go over there. This allows us the coverage that we need to maintain operations and maintain the needed level of infection prevention support."

The float IP can also be used to help support a team that is getting ready for a regulatory survey. "It makes everyone feel more supported that they are getting the help that they need," says Cary.



The strength of the IPC team has helped Cary retain IPs



PHOTOS CREDIT: KATIE CARY


Cary makes sure the person filling the role of float IP has opportunities for professional growth by giving them ownership of project work that helps drive the division forward. "I don't want them to feel like they are just floating from hospital to hospital." Cary helps her IPs follow their passions and grow as IP leaders. For example, an IP recently expressed interest in training and education, so Cary is working on meeting that professional growth opportunity for the IP.

The strength of the IPC team has helped Cary retain IPs. Even though the team spans two different regional areas, Cary says they are one group. "You would not know that they are in different cities. The team structure we've built has been influential in being able to recruit and retain people."



Advice

Cary's advice: Create a strong support system for your IPs. Her CMO believes in IPs having a seat at the table, as evidenced by the fact that most IP leaders in her division are at the director level. "They are having conversations with the CEO," says Cary. "That level of support for IPC is enticing."

In addition, don't be afraid to think outside the box when hiring, says Cary. "If you find the right attitude and outlook, you can absolutely teach the skills." 

Elizabeth Garman, CAE, is vice president, Communications, Marketing, and Practice Resources at APIC; Martha Sauchuk is senior director of marketing at APIC; Bob Hall is vice president of human resources at APIC; Alexis Cabill is communications specialist at APIC.

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Valley Senior Living,
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PEARLS OF WISDOM

for the Infection Preventionist

BY STEVEN J. SCHWEON

When I speak at orientation for new employees, my initial opening to the group is to request that they “raise their hand if they’re interested in hurting a patient.” I always receive cynical looks, hear nervous laughter, and, of course, nobody to date has ever raised their hand. However, an unexpected benefit is that I have their engagement *right away*.

As infection preventionists (IPs), patient safety is encoded in our DNA. I like using sayings, quotes, and aphorisms as gentle reminders to practice safely and prevent harm. These are just some of my favorite “pearls of wisdom” and how I adapted them in my infection prevention practice:

1 “Trust, but verify.” Made famous by President Ronald Reagan.

I was once told by a nurse manager that a pediatric inpatient was positive for pertussis and healthcare workers have been

‘exposed’! A pertussis exposure can have widespread institutional implications, be costly to manage, and require a great deal of time to curtail. This situation predates the adult tetanus-diphtheria-pertussis (Tdap) vaccine recommendations, yet the lesson is timeless. I thanked her for the information, hung up the phone, and took a slow, deep breath. I then went to the Pediatrics Unit and ensured the patient was on Droplet Precautions. Next, I searched for the paper medical chart, including the positive test result. Interestingly, the “positive” pertussis result was not in the chart. Upon additional discussion, the manager admitted the cough sounded like pertussis, so she thought the patient would test positive but

was negative. Instead, it was a different viral pathogen that did not require an exposure investigation.

Take-home message: I always trust the information that's provided to me, but I need to personally confirm the findings before I formally respond.

2 “If you take the right actions, you get the right results.”

(Unknown author).

Our memos, committee meeting minutes, and other written communications are subject to additional regulatory and legal review. Resultantly, I write about 80 percent of my “Infection Prevention and Control Committee” meeting minutes before the meeting. I do this to help prepare for the meeting, so my messaging is clear and concise. Hopefully, my communication also comes across confident and knowledgeable. Of course, I may need to modify some of the verbiages after the meeting, which is typically minor. Plus, it prevents the “agony” of penning the minutes afterward.

When reporting to other committees, I also prepare my discussion in advance and share it with the committee chair. This builds goodwill with the chair plus allows the opportunity for a courteous, advanced briefing. Again, it assists with remaining focused and present. Plus, the committee chair is typically thrilled to have my contribution to their meeting minutes, and it saves them precious time.

Take-home message: Daily, I need to own my personal messaging and communications to ensure accuracy and credibility.

3 “Never miss a good chance to shut up” Will Rogers.

As I neophyte IP, I attended a staff meeting to discuss Vancomycin-Resistant Enterococci (VRE) in an oncology unit. The staff asked me a question about changing the current nursing process in their department. The change was very benign and fundamentally sound, and I gave my wholehearted support. Several hours later, the oncology nurse manager was furious with me for deciding on nursing practice without consulting her first.

Take-home message: The optimal approach, regardless of how benign the change, is to thank the colleague for the question and respond to the individual with an update, regardless of the decision,

after additionally mulling it over. I always try to think of the downstream consequences of any decision I make and use the organizational chain of command for additional input. I cannot think of all the ramifications of a decision, and it helps to have additional perspective, plus it builds a bridge, instead of a barrier, with my colleagues. Always ensure you share the reasons behind the decision.


Additionally, when I have to present unpopular messaging, I find it best to privately share my communication with a trusted colleague first. This helps me to find the correct tone, anticipate questions, and subdue my emotions before going public.

4 “Stay on the message” (source unknown).

As a prominent individual in your organization, you may be cajoled by a co-worker to share, (wink-wink), *what do you really think?* While it may be flattering to feel worthy that your opinion is being solicited, nothing, in my view, is off the record in the workplace. Regardless of your viewpoint, it's typically best to adhere to the organizational messaging.

Take home message: When you rise to levels of leadership, consider that your actions now play out on the jumbotron for all to see and evaluate. Sometimes you'll get things wrong, and the ramifications may feel tectonic. Given the multitude of decisions you likely make each week, you will inevitably disappoint or enrage someone.

The very thorough CDC 2014 (<https://stacks.cdc.gov/view/cdc/25531>) and the CDC 2018 CERC (Crisis+Emergency+Risk+Communication) (https://emergency.cdc.gov/cerc/ppt/CERC_Introduction.pdf) manuals may help craft your messaging. Keep an open mind, stay sustainable, and remain flexible, so you don't get bent out of shape!

Additionally, I'm curious to know what “pearls of wisdom” influence your infection prevention practice. Please share with me at Sschweon@ptd.net. 

Steven J. Schweon, RN, MPH, MSN, CIC, LTC-CIP, CPHQ, FSHEA, FAPIC, is an infection prevention consultant with a specialized interest in acute care/long-term care/behavioral health/ambulatory care infection prevention challenges, including outbreaks.

Keynote Speakers at 2023 APIC Annual Conference and Exposition | *continued from page 31*

See him speak at “Global Vaccines and Vaccinations: The Science vs. The Antiscience,” Tuesday, June 27, at 8:30 a.m., in Orlando, Florida!

Q&A with: Peter Hotez

Prevention Strategist: What's your most important takeaway/learning point from the pandemic?

Peter Hotez: Vaccine access and equity depend on both empowering LMIC vaccine producers and recognizing the rise of antivaccine activism to counter it.

PS: As both a vaccine expert and autism parent, what is your largest challenge when educating members of the autism community?

PH: For both the autism community and those not a direct part of it, explaining why there is no vaccine link, and understanding the genetic basis of autism.

PS: In your opinion, what does the future hold for the world of vaccinations?

PH: Great promise on the technology side but increasing resistance to public acceptance because we're not addressing antivaccine activism.

PS: What message do you have for healthcare workers who struggle when educating colleagues and patients on the benefits and safety of vaccines?

PH: Vaccine refusal is now firmly entrenched in politics. Providing accurate and timely information on vaccines, while this is essential, it is not sufficient to ensure vaccine acceptance.

PS: What can our members expect to learn/hear at your talk?

PH: Details around the one-two punch of vaccine inequality: over-dependence on the multinational pharma companies at the expense of LMIC vaccine producers and the rise of antivaccine activism and aggression.

PS: How did you get interested in the work that you do with vaccine development and neglected tropical diseases?

PH: A lifetime passion in using science to benefit humanity. 

Did Infection Preventionists Experience Stress, Chronic Stress, Burnout, or All of the Above?

BY BRENNAN C. DORAN AND REBA A. BUSINSKY

In the spring of 2020, we stepped up to try and be everything to everybody, from our families at home, peers, our facilities, and the influx of patients. People can do pretty much anything short-term with a foreseeable endpoint. Yet, we have not had an opportunity to step back to a pre-pandemic existence. Many of us are still navigating the same challenges we faced at the beginning of the pandemic with a myriad of new ones.

Over the last three years, infection preventionists (IPs) have risen to meet the needs of our organizations and added professional obligations at a personal expense. Over the last few years, research articles have used a variety of terms to describe how we have experienced the pandemic: stress, chronic stress, and burnout. It can be challenging to

understand how a trigger word, burnout, might describe how we might feel or how it differs from routine stress or even chronic stress.

Stress is any type of change that causes physical, emotional, or psychological strain (World Health Organization, 2021). Stress involves changes affecting nearly every system of the body and initiates our “fight-or-flight”

response. In the short term, stress allows us to react quickly, giving us that boost we need to work through an outbreak investigation late on a Friday night before a three-day weekend. When that once-in-a-while long day at work evolves into weeks or months of long days, it becomes chronic stress. *Chronic stress* has been linked to the development of numerous physical and mental health conditions, including chronic fatigue, various metabolic disorders, depression, and immune disorders that can lead to burnout (Shaw, Labott-Smith, Burg, et al, 2022).

This chronic stress can impede performance,

continued on page 54



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GLOBAL OPP

BY CLAIRE JAI

In low-resourced areas, hospitals need assistance in developing their capacity and infrastructure for infection prevention. And the need is growing, not only to reduce patient harm and keep staff safe but also to prepare for future outbreaks. In-person assistance is definitely needed. But remote volunteering—while not an all-encompassing approach—can help facilities start the journey into the field of infection prevention, especially if the remote volunteers are supported by large NGOs.

Early in my career, I worked to help build infection prevention infrastructure in Africa. Later, reflecting on my experience as an infection preventionist during the pandemic and watching how things unfolded on a global scale, I developed a desire to return to that early work. As I had found it so rewarding and am not now able to travel or live overseas, I looked for remote opportunities, hoping to support one or more hospitals that would not

normally have access to individuals with infection prevention expertise. Supporting infection prevention has traditionally been seen to require the preventionist's physical presence, and I still believe this to be true. But if I learned anything from the pandemic, it was that a lot can be achieved remotely. And that includes foundational work to develop an infection prevention program.

An exhaustive online search yielded the name of an international, faith-based NGO, Catholic Medical Mission Board (CMMB), which provides long-term medical and developmental aid to communities affected by poverty and unequal healthcare access. Century-old CMMB works to strengthen and support targeted communities in Africa, Latin America, and the Caribbean by implementing healthcare programs, distributing medicines and medical supplies, and placing volunteers. The organizational focus on women's and children's health and delivering sustainable health services resonated with me. The volunteer program includes remote volunteering via a mentorship program that encompasses infection control. In July 2022, I applied as a volunteer.

The CMMB staff matched me to St. Theresa Mission Hospital (STMH) in Nzara, South Sudan, which had just started a committee for infection prevention and control and hygiene promotion (IPCHP), at the direction of medical



Hand washing station near the latrines; Filomena a TB nurse and IPCHP committee member.

director Dr. Maad Top with support from a five-year CMMB volunteer, infectious disease provider Dr. Helene Calvet. Timing is everything! We formed an infection prevention improvement project at STMH. Via Dr. Maad Top, my credentials were presented as a potential mentor to the IPCHP committee. They agreed to work with me, and we began.

STMH has 120 beds with a daily census of between 45 and 90 inpatients and around 90 outpatient visits. The hospital has access to solar power, basic lab tests,

ORTUNITIES



Maternity ward at STMH.



STMH campus, with the pediatric ward on the left, the nurses' station in the center, and the medical ward on the right.

and ultrasound services for OB-GYN. Primary conditions treated include malaria, gastrointestinal disorders, respiratory infections, and malnutrition. The hospital has a few outpatient departments, plus medical, pediatric, and surgical wards; a maternity/labor and delivery; an emergency room; and operating rooms (called “theatres” there). The facility is largely open air, is sited in a rural area near the South Sudan–Democratic Republic of the Congo (DRC) border, and would be considered extremely resource poor. (That is true despite the fact that it is one of the best-equipped healthcare facilities for many miles around.)

Dr. Calvert had already completed an infection prevention assessment of the

facility and provided some initial training with IPCHP committee members prior to my onboarding. Undertaken over a long weekend, the assessment was based on observations and interviews with the staff, who had readily provided meaningful examples of why infection prevention matters. The assessment found that many missed opportunities for hand hygiene and that basic supplies were lacking—including supplies of alcohol-based hand sanitizer (ABHS), paper towels, and the like. In the absence of ABHS, gloves were being used as a substitute for hand hygiene. Opportunities for improvement were numerous, especially around such standard precautions as safe injection, IV fluid practices, and waste

handling. Hospital waste segregation was found not to follow World Health Organization (WHO) guidelines; staff reports told of exposure to bloodborne pathogens by those working with the rudimentary incinerator and the open-air pit where paper waste is burned, and the cement-lined pits where plastics and sharps containers are disposed of.

Our project started with hand hygiene, since it is the basis for many infection prevention practices. To be successful, a hospital change is necessary, meaning ensuring the hospital has the necessary infrastructure in place to all the staff to perform hand hygiene. Compliance with hand hygiene is possible only if STMH



Waste management. Burn pit and incinerator.

ensures adequate infrastructure and only if a reliable and permanent supply of hand hygiene products is available at the right time and at the right location. The goal is to get dispensers at the point of care, that these dispensers continue to be well-functioning, and that they are reliably refilled so that they consistently contain ABHS.

While on-site, Dr. Calvet started working on getting the facility a reliable ABHS supply, knowing that sinks were present but insufficient in number and not sited at the point of use. A lack of funding meant that this hospital also lacked a consistent supply of ABHS; supplies donated during the pandemic had been used up. After it was found that acquiring additional prepared, ready-to-use ABHS was cost prohibitive (at US\$10 per 500cc bottle), it was decided to acquire the materials for staff to make their own ABHS; the WHO process for local production of ABHS promised to be more cost-effective. In Yambio, about 45 minutes by car from Nzara, Dr. Calvet found a pharmacy that could order concentrated ethanol (96%) in five-liter bottles from South Sudan's capital, Juba. Dr. Calvet donated the money for an initial 20-liter order, which took three

weeks to arrive. When individual ABHS dispensers proved hard to find, CMMB staff rose to the occasion and located a few empty dispensers. Jerry cans were used to mix the ingredients. When graduated cylinders or measuring cups were not available at the local market, Dr. Calvet donated a one-liter water bottle, with measurement markings on the side. Further markings were added to indicate the quantity of each ingredient that needed to be added. Hydrogen peroxide, which kills any spores in the containers themselves, was readily available in local pharmacies, and distilled water was available in the STMH lab. The WHO formula contains glycerol as a humectant, but it was omitted because it was impossible to source. With these simple tools and ingredients, STMH can now produce a continuous supply of ABHS—with continuing quarterly donations of US\$2,500 to US\$2,700 from Dr. Calvet's family donor-advised fund. A more sustainable funding source is being sought.

The current goal is to ensure ABHS dispensers are on trays and trolleys and at workstations and sinks. (Why at sinks? Liquid soap and paper towels are not available, so when soap and water are required, staff will

Healthcare-associated infections (HAI) constitute a significant burden yet go undocumented in many parts of the world. Every hospital, healthcare system, and nation sees these problems. Studies in low-resource areas have estimated that 15.5 of 100 patients (more than one in seven patients) suffer from an HAI—a rate that is two to three times higher than in high-resource areas. HAIs are a hidden epidemic. And if you cannot diagnose or detect these infections, you do not know they exist.

In low-resource settings, the HAI is likely especially high due to inadequate infrastructure for infection prevention and control (IPC)—or a total absence of infection preventionists and IPC—as well as lack of strategic direction at local and national levels, lack of financial governance, lack of microbiology laboratory support, and other missing or inadequate resources (e.g., inconsistent availability of hand hygiene products, handwashing facilities, PPE, and sterile goods).

use a bar of soap and shared cloth hand towel to dry their hands. Given the risk of cross contamination, Dr. Calvet and I agreed on the necessity of adding a final additional step, the use of ABHS.) These locations are not comprehensive to point of use, so future work will include designing dispensers that can be made locally for placement on each ward. The design will have to consider what materials are available locally, local workers' skill sets, security risk (e.g., pilferage of the ABHS). If local dispenser manufacture is not an option, we can explore the idea of having the next CMMB volunteer coming to STMH



Discussing prevention of diarrhea with mothers and children in the pediatric ward.



STMH staff speaking to medical and pediatric ward patients with their families on hygiene and its link to good health.

transport wall-mounted dispensers from the United States. However, this option could delay our work and does not allow STMH to be self-sustainable.

From my experience at STMH and elsewhere, I have learned that it is essential to come to the table without expectations. You must remember that you have not walked in your colleagues' shoes and that any agendas or thoughts you may bring on how to build infection prevention infrastructure would be only your own assumption. Imposing your own ideas will not help you build a trusting relationship with the local staff. This was highlighted by Dr. Calvet's experience at the first IPCHP committee meeting she attended, when she asked committee members what they considered the hospital's most important infection prevention issues. The assumption might have been that we would hear about the need for handwashing supplies or access to personal protective equipment (PPE). Instead, Dr. Calvet learned about livestock getting into the hospital campus and flies entering the wards,

attracted by rotting mangoes. Dr. Maad Top addressed these serious issues. Later, Dr. Calvet presented her assessment's key findings to IPCHP committee members. Most members turned out for this presentation and enjoyed tea, snacks, and education on more traditional infection prevention concerns. Dr. Calvet included some amazing "what is wrong with this picture" slides taken during the assessment, and Dr. Maad led a session of discussion and problem solving on how to begin addressing the issues. Dr. Calvet followed up with information on ABHS materials and trained three committee members on how to make ABHS. Although the concentrated ethanol had not yet arrived, STNH's infection prevention journey had begun.

Work to ensure adequate ABHS supplies needs to be combined with policy development and education. Currently in the project's first phase, we are identifying and developing policies and providing supporting educational materials to the committee, for later dissemination to relevant

staff. Separately, building on Dr. Calvet's assessment, I used WHO hand hygiene guidelines and drew on my experience in Africa to write STMH's first ever infection prevention policy, a hand hygiene policy that would work with current STMH infrastructure. This required identifying a system for numbering policies that could expand outside of infection prevention—something I had never thought of before. Based on this policy, I developed and gave the committee a virtual hand hygiene training, which revisited the making of ABHS and covered how and when to perform hand hygiene. In my work, I had to take into account that staff have varying levels of education and varying English-language skills. To simplify the 5 Moments of Hand Hygiene, we are working toward implementing the patient zone concept at STMH, ensuring ABHS in appropriate locations to facilitate compliance with our hand hygiene protocols. As homework, each IPCHP committee member went to one ward or clinic and identified all the items that



Initial training with Dr. Calvert.

would be in and out of the patient zone. Based on this activity, I am creating ward-specific posters that IPCHP committee members can use to train staff upon hire and retrain them annually. Over time, the committee will track activities using other tools I provide to monitor and evaluate policy compliance, resource access, and other activities critical to infection prevention, so that appropriate hand hygiene practices continue at STMH long after the initial work has been completed.

Also toward that end, we are asking current CMMB volunteers as well as IPCHP members to provide objective feedback on the status quo so we can adjust the project to reinforce hand hygiene practices. Infection prevention requires culture shift, and that will take time, but the committee is motivated and understands the importance of infection prevention. This is half the battle.

Remote volunteering is not without challenges. I have learned to listen first; ask a lot questions to avoid making assumptions; keep commitments; and deliver results (while enjoying the experience!). Adapting and applying guidelines to settings completely different than those to which you are accustomed can be testing. Patience is essential. You cannot count on internet connectivity. You also have to be flexible

about your availability to work. Some weeks I put in 10 to 20 hours for STMH; on other weeks, I am simply waiting for those at STMH to provide feedback. Working across time zones can require late nights and early mornings. Language gaps can make achieving mutual understanding a slow process. And, although you need health facility leadership who can provide details on current practices and capabilities, you don't always find it. Fortunately, I have had coordination by CMMB and insight from those who have visited and who work at STMH, especially Dr. Calvert, Dr. Maad Top, and the committee members. Without these relationships, this project could not move forward.

Thinking how this project has broadened my infection preventionist's perspective and has given me lessons to take back to my U.S. workplace, I can only hope that more preventionists get involved in remote volunteering and that other NGOs and organizations recognize the need for such positions at the organizational level as well as at the hospitals they support, toward a more cohesive approach to building infection prevention infrastructure globally. We need more such projects.

To grow the field on a more global scale, a large pool of infection preventionists is likely

available to lend a hand remotely. But this volunteer work requires financial support as well as participation by subject matter experts. And unfortunately—although the Covid-19 pandemic has jump-started public recognition of the value of infection prevention among people outside our field—infection preventionists' work is underrecognized and underfunded. The STMH project is based solely on donations from Dr. Calvert. If those funds run out, so do the resources to make ABHS—for example—and with that will go any hope of sustaining infection prevention practices at STMH. Advocating for and supporting this work through both financial and expertise means is required for an infection prevention project to be successful.

Now I am looking into the future. I have begun to develop an STMH standard precautions policy that will continue and expand the hospital's infection prevention infrastructure, and I am looking forward to visiting STMH in the future to provide further support. I have been honored to work with the teams at both CMMB and STMH, and I appreciate the trust my amazing colleagues have placed in my expertise.

In the span of less than a year, despite the constraints of the setting and scarce



Making ABHS.

resources, the hospital has made a huge amount of progress; staff members have become IP leaders in the Nzara area. Such progress reflects both organizational and individual dedication to infection prevention at STMH. Fueled by its passion and the motivation to become a leader in infection prevention, I have no doubt that the hospital will succeed in achieving Dr. Maad Top's vision of STMH as a center of excellence for infection prevention.

Learn more or to become involved, visit <https://cmmb.org/preventinfection>. **Ps**

Claire Jai, MSc, CIC, is Infection Prevention Director at Banner University Medical Center—Phoenix with over 15 years of experience in epidemiology and infection prevention in the U.S., and Africa.

I had the opportunity to speak to Dr. Maad Top about the formation of STMH IPCHP Committee.



Why did you decide to establish the IPCHP Committee at STMH?

I started at STMH in late December 2021, and I made the decision to establish this committee after a service mapping in January 2022. The committee comprises 15 members from different departments, wards, and units. The purposes are fourfold. First, we need to enforce standard precautions: Nzara has a history of infectious disease outbreaks (specifically, Ebola viral disease, or EVD) and borders DRC, which had an EVD outbreak not long ago. Second, we aim to guard

against potential animal-borne infection. The hospital is not completely fenced, so it is difficult to keep pigs, goats, ducks, dogs, and other domestic animals off the premises. A new chain-link fence should help to reverse the situation. Third, we need to improve laboratory biosafety—testing for HIV, TB, Covid-19, HBV, HCV—so that we achieve Biosafety Level 4. Fourth, we need to improve waste segregation and management.

What are you hoping to gain from this project in collaboration with CMMB?

I am hoping for sustainability and for a knowledgeable and well-trained staff. Additionally, I hope to see the IPCHP team well equipped for its mission.

What is your vision for the future of IP at STMH?

My vision is for STMH to be an IP and control referral center, offering trainings

and research, adopting policies, and setting an example of good practices in action. To realize this vision, I want to train the IPCHP committee members (so that they are better certified), as they are the nucleus of our IP journey. We also need to provide literature and other materials, references, and presentations to enhance a culture of learning and research among IPCHP members and hospital staff in general.

What are your thoughts on the remote volunteering activity in building IP capacity at STMH?

It was a game changer. It helps the IPCHP committee members' performance, especially on hand hygiene and glove use. The remote volunteers' activities enabled members to better understand the subject. Our policy will assist us in reducing glove use, improve handwashing practices, and enhance waste segregation and management among clinical and cleaning staff.

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feature

The one and only CIC in Jamaica: An interview with **NICOLA EWEN**

Nicola Ewen, BPharm, MPH, PMP, CIC, is a member of the Association for Professionals in Infection Control and Epidemiology where she serves as a member of the Communications Committee. She is the only Certification in Infection Control (CIC)-certified Jamaican professional. She is a Consultant Epidemiologist with the Ministry of Health and has worked for many years as the Regional Epidemiologist in the South East Regional Health Authority. As a professional in the field, Ewen has been actively involved in research ethics, epidemiology, health systems development, and infection prevention and control at both the regional and national level. In addition to being a competent CIC, she is a certified project manager and monitoring and evaluation specialist. Her work in infection control over the years has been grounded in sound application of data driven decisions and best practices.



PHOTO CREDIT: NICOLA EWEN



Infection prevention is a global community and we appreciate the efforts of CICs who have answered the call for assistance.

Prevention Strategist: How did you get into IPC?

Nicola Ewen: As a public health specialist I was a competent data manager and this catalysed my transition into epidemiology. As a regional epidemiologist my scope of practice spanned community, primary and secondary care, and a common thread between them was infection control. In IPC, I utilize my critical eye and skills in epidemiology, particularly when engaging in audits or infectious disease investigations.

PS: What inspired you to pursue your CIC?

NE: I became a CIC because I found the APIC content interesting and relevant to my practice. The CIC allowed me to increase and validate my knowledge in infection control and epidemiology. As I continued to gain experience in infection control and epidemiology, I wanted to increase my competencies. As an allied health professional, the CIC also aligns my competencies with other professionals in the field.

PS: What would you like the readers to know about Infection Prevention efforts in Jamaica?

NE: Infection Control in Jamaica is an active and vibrant field. Countries address IPC differently based on resources, and the epidemiologic profile in Jamaica is no different—vaccine preventable diseases, tropical medicine, disaster surveillance, emerging and re-emerging infectious disease conditions, are all just some of the major focuses. The experience in field epidemiology and infection prevention control and control communication is invaluable.


PS: How will a CIC for fellow Infection Preventionists in Jamaica, support the profession?

NE: CIC for fellow professionals will propel the profession forward in Jamaica; more importantly, it will create greater core human resources for improving policy and practice in the country. An increase in CICs will also increase the country knowledge bank of successful exam candidates and allow for a higher rate of diffusion of information and create larger, more diverse CIC study groups that can assist more professionals to achieve their certification.

PS: What approach do you plan to take to increase CICs in your country?

NE: Communication is key, many persons still do not know that there is a CIC certification. Aside from personal development, until recently there was no push from the statutory health bodies to get persons certified. There is a practice and knowledge gap to bridge. In addition to the public private partnerships, infection control workshops and utilizing the resources provided by APIC, experienced CICs have been assisting with the initiative. As this initiative progresses I hope that eventually we will have a snowball effect in the country.

PS: What else would you like to share with APIC members?

NE: The differences and gaps in practice make studying and applying some of the exam content difficult. Infection prevention is a global community and we appreciate the efforts of CICs who have answered the call for assistance. 

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ability to focus, executive functioning, and increase anxiety.

The *APA Dictionary of Psychology* (2015) describes *burnout* as “physical, emotional or mental exhaustion, accompanied by decreased motivation, lowered performance and negative attitudes towards oneself and others.” Chronic stress and burnout have a dramatic effect on the brain and are responsible for the thinning of the gray matter of the prefrontal cortex of the brain (LaMott, 2022). The prefrontal cortex allows us to do complex decision-making and to be able to have thoughtful, abstract reasoning. Burnout can also enlarge the amygdala part of the brain responsible for our “fight-or-flight” response when in danger. The impact is our ability to be self-aware, view situations from different perspectives, and leverage our abstract reasoning. It essentially deconstructs us to a more primitive state, and we become conditioned to see the world as a cold and dangerous place.

The main difference between stress and burnout is that stress, even chronic stress, can be temporary and there is hope it will end. With the pandemic, we thought and hoped it would be temporary. However, there was likely a flashpoint for each of us when we realized it wouldn't ever be truly over.

Instead, we were working toward defining a new normal, a world we are still working to understand and define.

What does this mean for those of us who relate to the description of burnout in ourselves and each other? What it means is that you are in good company and not alone. In an article published by Melnyk, Hsieh, Mu, Jopp, & Miller (2022), the authors focused on mental health, physical well-being, and engagement of IPs in activities that contribute to a healthy lifestyle. Of the 6,000 randomly selected APIC members surveyed, 926 responded, or a 15 percent response rate. The results indicated 65.2 percent had symptoms of burnout, 75 percent reported worsening mental health, and 60 percent reported poorer physical health due to stressors associated with the COVID-19 pandemic. A response to this article was sent as a Letter to the Editor by Smathers, Gilmartin, and Stone (2022), which highlighted ways IPs can seek joy in their work and address burnout by creating awareness and focusing energy and attention on topics that matter most to them and their teams. In future articles, we will discuss how chronic stress and burnout are impacting IPs in 2023 and how to leverage self-care and care of others to overcome it. **Ps**

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