

SUMMER 2021 • VOLUME 14 NUMBER 2

Prevention *strategist*

Reducing the risk of infection

RESILIENCE AND LESSONS LEARNED

**Equity, Diversity, and Inclusion:
A Call to Action**

**The Importance of Leadership and Social
Support on Mental Health and Wellbeing**

**Returning to the 'New Normal'
(Whatever That May Be)**



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Bent
but not
broken by
COVID-19



BY ANN MARIE PETTIS

THERE IS NO denying that SARS-CoV-2 has tested the resilience of our nation, healthcare in general, and infection prevention in particular. Infection preventionists (IPs) have been forced to sanction practices which would never have been considered prior to the pandemic. The term “desperate times call for desperate measures” never resonated more. We have faced a scarcity of critical resources, shifting and conflicting expert recommendations, and worst of all, loved ones and colleagues stricken by COVID-19, all of which have contributed to stress. As a result, we are battle weary, and weariness unchecked can lead to desperation.

Resilience can be defined as the capacity to recover quickly from difficulties, or the ability of an object to spring back into shape; in other words, to bend but not break. Over the last year, IPs have demonstrated those characteristics like never before. In her book, *How Resilience Works*, Diane Coulter states that a resilient person possesses three traits: a staunch acceptance of reality, a deep belief that life is meaningful, and an uncanny ability to improvise. Each of these traits have been obvious in IPs throughout the pandemic. According to the Bounce Back Project, a collaboration of physicians, nurses, hospital leaders, staff, and community partners that promotes health through happiness, resilience is made up of five pillars: self-awareness, mindfulness, self-care, positive relationships, and purpose. Each of these can be developed and strengthened to deal with stress, experience happiness, and become more resilient.

Resilience is a positive outcome that stems from a sense of wellbeing, which in turn comes from judging life positively and thereby feeling good. There are many reasons to work toward wellbeing: improved immune system, decreased risk of disease or injury, and longevity are just a few. Experts believe there are personality factors associated with a sense of wellbeing; optimism, extroversion, and strong self-esteem. Even if we can't change our personality or natural inclinations, there are things we can do to stack the deck toward wellbeing such as regular exercise, adequate sleep, healthy diet, and good humor. Wellbeing involves mind, body, and soul. APIC offered a four-part webinar for members called IP Recharge: A Well-Being Series that includes yoga, meditation, and emotional support through networking. An “attitude of gratitude” is also key to wellbeing. I am grateful for having meaningful work without loss of income and alongside amazing colleagues. I am grateful that my family and myself have remained safe from COVID-19.

How truly resilient IPs are but how quickly we “spring back into shape” remains to be seen. We must capitalize on the lessons COVID-19 has taught us so we can emerge personally and professionally with a stronger, clearer commitment to our mission: a safer world through prevention of infection. I am confident that we are stronger than ever. COVID-19 has perhaps bent us but surely we are not broken and our resilience is on display for all to see.

Ann Marie Pettis

Ann Marie Pettis,
RN, BSN, CIC, FAPIC
2021 APIC President



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APIC is
'all in'



BY DEVIN JOPP

YEARS AGO, I had the privilege to get to know and be mentored by the Honorable Louis W. Sullivan, MD, who served as the 17th Secretary of Health and Human Services during the George H. W. Bush administration. He was the second Black American to hold this position. In our discussions, Dr. Sullivan has often talked about the ideal that our country was built on, which is that all people are created equal. However, he would also note, while that ideal has never been realized, as long as the country earnestly worked to make it a reality, he would be “all in.”

In this edition of *Prevention Strategist*, Dr. Sullivan’s words ring throughout. We must be all in ourselves and all in our various communities. *Prevention Strategist* editorial panel member Shaunté Walton, MS, CIC, sets the stage for action in her article, “Equity, Diversity, and Inclusion,” as she frames what is meant by these terms and how we move from awareness, to action, to improvement, and to making a difference in our own organizations. She challenges us to “be kind, be patient, and be bold as we strive to create a better world.” She challenges us to be all in.

Collectively, as your professional home, we must model the way in taking these bold steps. In that vein, APIC has three key initiatives. First, the APIC Board of Directors recently approved the formation of a Diversity, Equity, and Inclusion (DEI) Task Force to study, recommend, and implement an organization-wide DEI agenda. Second, APIC’s home office here in Arlington, Virginia, has created a task force that is working to help guide our own internal efforts to conduct training, engage staff, and build a culture that centers on DEI in the workplace. Third, APIC has formed a new group to explore how as a profession we should address health inequity and health disparities in the field of infection prevention and control and make recommendations for research, education, and action to address these inequities and disparities.

As Ms. Walton notes in her article, this is indeed a journey, and I’m proud of the steps that we are taking at APIC to mobilize our own efforts. We have a long way to go, but as the old adage goes, “a journey begins with a single step.”

Devin Jopp, EdD, MS
APIC CEO

Prevention *strategist*

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MANAGING EDITOR

Elizabeth Haberkorn
ehaberkorn@apic.org

CONTRIBUTING EDITORS

Kayley Deaton
kdeaton@apic.org

Elizabeth Garman, CAE
egarman@apic.org

PROJECT MANAGER

Russell Underwood
runderwood@naylor.com

ADVERTISING

Brian Agnes
bagnes@naylor.com

GRAPHIC DESIGN

Amit Kumar Singh

EDITORIAL PANEL

- Feah Altura - Visan, MAN, CIC
- Lynn M. Carosella, MSN, MA, RN, CIC
- Kathryn (Katie) Galvin, MS, MLS (ASCP)CM, CIC
- Kathryn Godsey, BSN, RN, CIC, CPHQ, LSSGB
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- Jessica Hayashi, MS, RN, CIC, CPHQ, FACHE
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- Saskia Popescu, PhD, MPH, MA, CIC
- Claudia Skinner, DNP, RN, CIC, CCRN-K, NE-BC, FAPIC
- Jonathon Teter, MS, CIC
- Shaunte Walton, MB(ASCP), CIC
- Jacqueline Whitaker, RN, MS, LHRM, CPHQ, CIC, FAPIC

CONTRIBUTING WRITERS

- Vicki Allen
- Heather Bernard
- Rich Capparell
- Sylvia Garcia-Houchins
- Elizabeth Garman
- Janet Glowicz
- Patti Grant
- Elizabeth Haberkorn
- Nancy Hailpern
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MISSION

APIC is creating a safer world through the prevention of infection. APIC’s nearly 16,000 members develop and direct infection prevention and control programs that save lives and improve the bottom line for healthcare facilities. APIC advances its mission through patient safety, education, implementation science, competencies and certification, advocacy, and data standardization. Visit us at www.apic.org.

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Checking
in



BY JANET GLOWICZ

AS SUMMER APPROACHES, it is astonishing to think more than a year has passed since COVID-19 began to impact the infection prevention and control (IPC) community. Through these tumultuous times, IPs and CICs have stepped up as industry leaders, giving all they have physically and mentally. While we remain vigilant in our efforts to control the pandemic, please remember to check in with yourself and your colleagues to ensure mental and physical wellbeing.

Progress on new CBIC initiatives

Over the past couple of months, the CBIC Board of Directors has been working diligently to continue to provide pathways to assess and maintain infection prevention competency in all healthcare settings. My first column as the 2021 CBIC President addressed the incredible progress made by the CBIC Board of Directors and CBIC staff in launching a revised IPU Manual and Digital Badging to allow CICs to promote their certification. We have already received wonderful feedback from CICs sharing their badges on social media.

The reliability and validity of the CIC® examination is ensured through the test development process. CBIC performs a Practice Analysis every 4 to 5 years. This is followed by the creation of an updated exam. Each item, or question, in the new exam must be validated and pass/fail standards reset. The 2020 CBIC Practice Analysis survey and item writing have been completed. The next step is to have eligible candidates take a beta test of the revised version of the exam. As the new standards are validated, the current examination will be unavailable for testing. Please consider being a beta tester! CBIC will share communication when candidate applications are open for acceptance.

CBIC routinely evaluates eligibility requirements of each certificate by monitoring trends found among applicants and questions or concerns raised by certificants. The a-IPC™ measures readiness to practice IPC, the CIC examination measures proficiency gained by experience. To further differentiate the a-IPC from the CIC and to reduce subjectivity in the eligibility requirements, CBIC has updated requirements for CIC Initial Certification and Lapsed Certificants effective June 1, 2021. The a-IPC will remain available to anyone who desires to show readiness to work within the profession of IPC. Individuals taking the CIC exam must have a post-secondary degree in a health-related field and hold direct programmatic responsibility for IPC demonstrated by actively working in the field for a certain number of hours in the years prior to taking the exam.

Looking ahead

Connecting virtually has become the new normal in this new world we are living in. We had high hopes to be able to see you in person this year in Austin, however, we are pleased to have the opportunity to exhibit at the virtual APIC Annual Conference in June. We look forward to connecting with you to talk about certification and answer questions about the CIC, a-IPC, and IPU!

With appreciation,

Janet Glowicz, MPH, PhD, RN, CIC, FAPIC
2021 CBIC President



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1. Arden S. Does Universal Nasal Decolonization with an Alcohol-Based Nasal Antiseptic Reduce Infection Risk and Cost? Open Forum Infect Dis 2019 Oct; 6(Suppl 2): S26. 2. References list: nozin.com/clinical-outcomes. Outcomes reported by actual users. Your results may vary. Nozin® Nasal Sanitizer® antiseptic is for nasal decolonization. ©2021 Global Life Technologies Corp. All rights reserved. Made in USA. Nozin®, Nasal Sanitizer®, Popswab® and NOVASM are trademarks of Global Life Technologies Corp. Nozin® Nasal Sanitizer® antiseptic is an OTC topical drug. No claim is made that it has an effect on any specific disease. Patent nos.: nozin.com/patents.

CONGRATULATIONS TO THE 2021 APIC AWARD RECIPIENTS

President's Distinguished Service Award, in honor of Pat Lynch



**Terri Rebmann, PhD,
RN, CIC, FAPIC**

Terri Rebmann, PhD, RN, CIC, FAPIC, is the recipient of the *2021 President's Distinguished Service Award*. The award, which honors the work of Patricia Lynch as one of APIC's pioneering members and its first national president, is given to an individual who has made major contributions to the profession through service within APIC.

As a teacher, expert, and leader, Rebmann's contributions to APIC have been numerous and varied. Rebmann, who is Director of the Institute for Biosecurity, Professor in the Department of Epidemiology & Biostatistics, and a Special Assistant to the President at Saint Louis University in St Louis, Missouri, is also a member of APIC's COVID-19 Task Force. In this capacity, she helped to write an APIC White Paper on lessons learned from the pandemic and presented numerous webinars to ensure that APIC members and other stakeholders, including nurses, understood changing guidance on transmission of SARS-CoV-2 and PPE. As part of her work on the COVID-19 Task Force, she led the execution and analysis of APIC's two nationwide PPE surveys and focus groups with APIC members. The knowledge gained from these surveys and focus groups was vital to APIC's understanding of PPE constraints and has been used to advocate for additional resource availability.

Rebmann served as president of her local APIC chapter, was a member of APIC's national Ebola Task Force, and was chair of APIC's national Emergency Preparedness Committee. While on the Emergency Preparedness Committee, she oversaw development of a number of pivotal position papers and guidance documents for APIC including "Infection prevention and control guidance for shelters during disasters," "Extending the Use and/or Reusing Respiratory Protection in Healthcare Settings During Disasters," "Infection Prevention for Alternate Care Sites," and "Infection Prevention for Ambulatory Care Centers During Disasters." She currently serves as a board member of the Certification Board of Infection Control and Epidemiology (CBIC) and is a former member of the editorial board for AJIC.

A global leader on bioterrorism, disaster response, and infectious diseases, Rebmann has published more than 130 papers and articles and is a sought-after speaker. As her many nominators have noted, because of Rebmann's efforts, APIC is a stronger organization, and the world is a safer place.

APIC-SHEA Award for Lifetime Contribution to the Field of Infection Prevention and Epidemiology



Anthony Fauci, MD

Anthony S. Fauci, MD, is the recipient of the inaugural *APIC-SHEA Award for Lifetime Contribution to the Field of Infection Prevention and Epidemiology* for his contributions to the field throughout his career.

As director of the National Institute of Allergy and Infectious Diseases (NIAID), Dr. Fauci has been a tireless and fearless leader for our nation throughout the COVID-19 pandemic. Dr. Fauci was appointed director of NIAID in 1984 and oversees an extensive portfolio of basic and applied research to prevent, diagnose, and treat established infectious diseases such as HIV/AIDS, respiratory infections such as COVID-19, diarrheal diseases, tuberculosis, and malaria as well as emerging diseases such as Ebola and Zika. Guided by science, Dr. Fauci has advised seven U.S. Presidents on numerous epidemics, emerging pathogens, and other domestic and international issues.

His contributions over the past 37 years to infection prevention and control have saved millions of lives around the world. As a public health expert and advocate for the truth, Dr. Fauci will remain one of the most trusted infectious diseases physicians and one of the most respected clinical immunologists in history.

Healthcare Administrator Award



Darla Perdue, MSN, RN

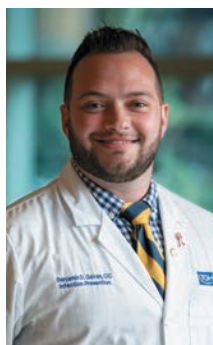
Darla Perdue, MSN, RN, is the recipient of the *2021 Healthcare Administrator Award*. The award recognizes the pivotal role that healthcare leaders play in establishing an organizational culture that enables and supports infection prevention and control (IPC).

Under Perdue's leadership as Chief Clinical Officer for Vibra Healthcare, IPC became an organizational priority. In 2017, Perdue added a VP of Infection Control position to the corporate clinical team, and by doing so established the importance and value of infection prevention within the organization. Perdue also developed a standardized orientation process for new infection preventionists to ensure that they have the training and skills they need to succeed.

As a result of Perdue's commitment to IPC, Vibra Healthcare has seen sizable reductions in healthcare-associated infection rates: a 51% reduction in central line-associated bloodstream infections in long-term acute care; a 30% reduction in catheter-associated urinary tract infections in long-term acute care; a 130% reduction in catheter-associated urinary tract infections in rehabilitation facilities; a 46% decrease in lab-identified *Clostridioides difficile* cases in long-term acute care; and a 37% decrease in *C. diff* in rehabilitation facilities.

Perdue is a strong advocate for zero harm, communicating her expectations for reducing infections and other patient safety events with leaders and holding the leadership accountable by having the corporate clinical team identify activities that can reduce harm events, whether those are falls or infections.

Emerging Leader in Infection Prevention and Control Award



**Benjamin D. Galvan,
MLS(ASCP), CIC**

Benjamin D. Galvan, MLS(ASCP)^{CM}, CIC, is the recipient of the inaugural *Emerging Leader in Infection Prevention Award*. Since 2016, Galvan has been an active APIC member and has showcased his innovative and collaborative skillset as well as his dedication to the infection prevention profession.

Galvan's drive and commitment to improving healthcare was evident in the many projects he managed and contributed to while at Advocate Aurora Health's Illinois Masonic Medical Center in Chicago. These projects focused on HAI reduction, hand hygiene, environment of care, technology/innovation, and standardization of high-level disinfection. Several of these performance improvement projects resulted in impressive outcomes such as a significant reduction in CAUTI events, a reinvigorated hand hygiene compliance program, and a culture shift towards shared accountability with hospital cleanliness. Galvan also helped design and implement a mobile phone application that greatly improved data collection and streamlined the auditing process for indwelling medical devices at two medical centers within the Advocate Aurora Healthcare System. A few of these projects were accepted as abstracts at the National APIC conferences and can be found published in *AJIC*.

Galvan is currently an Infection Preventionist at Tampa General Hospital in Tampa, Florida and enrolled at the University of South Florida pursuing a Master's Degree in Public Health with a concentration in Infection Control. He is presently serving on the national APIC Communications Committee and is an active member of the Bay Area APIC Chapter (BAPIC), volunteering as a member of the social media committee. Galvan is passionate about advocating for medical technologists as equally suited candidates for new infection prevention positions and is determined to further his knowledge and ability to drive collaborative process change while improving patient outcomes within his new facility.

2021 AWARD FOR AJIC PUBLICATION EXCELLENCE

Hongyun Wang, BSc

A qualitative study on the psychological experience of caregivers of COVID-19 patients

2021 BLUE RIBBON ABSTRACT AWARDS

Mendee Livingston, CIC, MPH, MLS (ASCP)

CLABSI Prevention—Using a 90 Day Sprint

Patrick A. Palmieri, DHSC, DPHIL(HON), EDS, PGDIP(OXON), MBA, MSN, RN, CPHQ, CPHRM, FAAN

Family Function and Treatment Adherence of People Infected with tuberculosis in Peru: A Multicenter Observational Study

Hanako Misao, RN, PHN, RNM, MSN

International Comparison of the Competencies of Infection Preventionists among Career Stages Between the United States and Japan

Holly Taylor, MPH, CIC

Use of Retired Infection Preventionists to Supplement Infection Prevention Department Staffing

IMPLEMENTATION SCIENCE ABSTRACT AWARD

Fozia I. Steinkuller, MPH, CIC

UT Physicians, Houston, TX

Implementation of a Successful Sterilization and High Level Disinfection Outpatient Program

NEW INVESTIGATOR ABSTRACT AWARD

Kathy Auten, RN, MSN, CIC

Saint Luke's, Kansas City, MO

Intentional Collaborative Rounds Focusing on Eyes on the Lines: A CLABSI Reduction Project

WILLIAM A. RUTALA ABSTRACT AWARD

Michelle A. Ozbun, PhD

The University of New Mexico School of Medicine
Albuquerque, NM

Assessing the Efficacy of Human Papillomavirus Disinfection and the Risk of Transmission from Clinical Lesions

HEROES OF INFECTION PREVENTION AWARDS

Khaled Alnafee, MHA, FAPIC, PMP, CPHIMS, CPHQ

Category: IPC Informatics

King Faisal Specialist Hospital and Research Center; Riyadh, Saudi Arabia

Lisa Sturm, MPH, CIC, FAPIC

Category: Leadership

Ascension; Fenton, MI

Leslie Lloyd and Jeremy Gibson-Roark

Category: Quality Improvement

Det Norske Veritas; Lancaster, SC

TGH Infection Prevention Team

Category: IPC Operations

Tampa General Hospital; Tampa, FL

The Heroes program is supported by a grant from BD, an APIC Strategic Partner.

CHAPTER EXCELLENCE AWARDS

Member Support: Delaware Valley and Philadelphia (large)

Education, Communication, and Information Resources: San Diego/Imperial (large)

Education, Communication, and Information Resources: Greater Atlanta (large)

Synergistic Alliances: Puget Sound (large)

Synergistic Alliances: West Virginia (medium)

CHAPTER LEADER AWARDS

Neeraja Ganeshraj, MPH, CIC;

Dallas-Fort Worth Chapter

Michelle Schmitz, BS, CIC; Badger, WI Chapter

Kristin M. Smith, RN, MSN, CIC;

New England Chapter

Lance Williamson, MSN, RN, CIC; Greater Kansas City Chapter

APIC JOINS ANA TO CREATE COVID-19 VACCINE RESOURCES

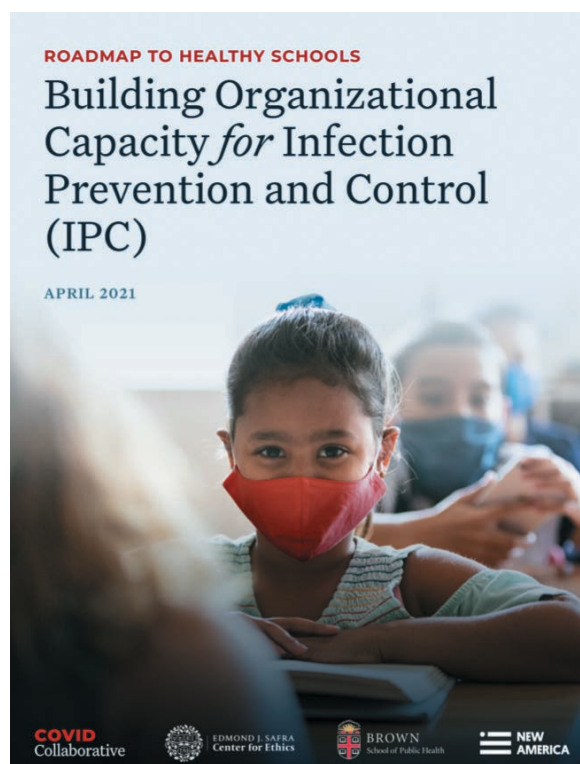
It only makes sense that infection preventionists would be invited to partner on a public awareness campaign to spread accurate COVID-19 vaccine information. With that in mind, American Nurses Association (ANA), APIC, and 18 other leading nursing and healthcare organizations launched COVID Vaccine Facts for Nurses (<https://covidvaccinefacts4nurses.org/>), an educational resource to bring “critical, current, and culturally sensitive COVID-19 vaccine information” for nurses on the frontlines and those caring for patients in communities across the nation.

The resource is dedicated to providing relevant, accurate, and up-to-date information on the pandemic and expert perspectives about the safety, efficacy, and importance of COVID-19 vaccines. The site features: expert videos; FAQs; nurse-specific information; social media-friendly resources; culturally relevant conversation; and job opportunities. It will be continually updated and address relevant concerns that come up with the pandemic. It is sponsored by Johnson & Johnson, one of the makers of the three current COVID-19 vaccines available in the U.S.

APIC CO-AUTHORS ROADMAP TO HEALTHY SCHOOLS

APIC was part of a broad partnership of organizations that developed a new suite of tools to guide schools for restarting in-person learning. Developed in partnership with the COVID Collaborative, Harvard University Center of Ethics, the Brown School of Public Health, and New America, APIC was part of this task force and was the primary author on the writing team for infection prevention and control in primary and secondary school settings. We are grateful to a group of APIC volunteers for their dedication and incredible work in drafting the guidance on school-based infection prevention and control measures that are included in the materials. Group members included: Sarah Bishop, Crystal Heishman, Tim Landers, Nicole Nomides, Karoline Sperling, Carol Vance, APIC president Ann Marie Pettis, and CBIC president Janet Glowicz. The tools may be accessed here <https://www.covidcollaborative.us/infection-prevention-and-control-in-schools> and include:

- A *Roadmap to Healthy Schools* that provides a tactical overview of the core elements of effective IPC, complete with promising practices and case studies from schools and districts that have successfully resumed in-person instruction this year;
- A *consensus statement from leading scientists* that builds on the CDC guidance and makes clear the evidence of the effectiveness of layered IPC measures in schools;
- A *use of funds advisory memo* that outlines recommendations for deploying authorized funds for IPC practices throughout the K-12 sector, including suggestions for facilities, training, and workforce investments.



COVID COLLABORATIVE

INTERNATIONAL IP DAY 2021

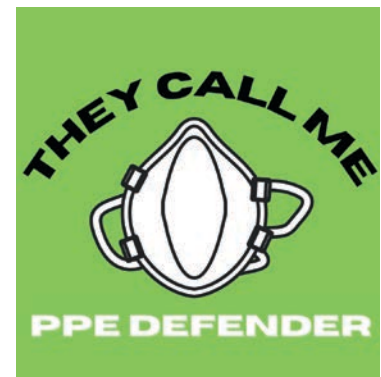
On April 2, APIC celebrated the second International IP Day. #WeLoveOurIPs dominated our social media pages and fun IP-related graphics illustrated our love and appreciation for all things IP.

APIC staff also thanked our hard-working IPs by creating a video that you can watch at <https://apic.org/news/second-annual-ip-day-weloveourips/>, and you can also download the graphics and GIFs

appropriately sized for Facebook, Twitter, and Instagram. You can also read shared COVID-19 stories and submit your own.

We appreciate you, our IP superheroes! We can't thank you enough.

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IN MEMORIAM, MARTIN S. FAVERO (1937-2021)



The world of IPC lost a giant with the passing of Martin S. Favero on March 28, 2021. Favero attained a national and international reputation as an outstanding scientist, lecturer, researcher, and infection preventionist in the fields of disinfection, sterilization, and antisepsis. Working for employers like the CDC and Johnson & Johnson, Favero's groundbreaking work in infection control and sterilization procedures to assure cleanliness in clinical environments influenced healthcare management and the welfare of thousands of patients experiencing hospital care throughout the world. In 2003, APIC honored Martin Favero as the first recipient of a Lectureship Award named in his honor, which recognizes significant lifetime contributions to the fields of disinfection, sterilization, and antisepsis. An editorial by his colleagues in the April 2010 issue of *AJIC* details Favero's numerous scientific contributions. To read the editorial, go to [https://www.ajicjournal.org/article/S0196-6553\(10\)00421-9/abstract](https://www.ajicjournal.org/article/S0196-6553(10)00421-9/abstract). P3

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Making IPC a priority in nursing homes

BY LISA TOMLINSON, NANCY HAILPERN, RICHARD CAPPARELL, AND ABIGAIL RICHARDS



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IT IS NOT uncommon for infection prevention and control (IPC) to be considered a low priority in long-term care facilities, and therefore, infection preventionists (IPs) must work with less resources and staff than in other settings. Often IPs take on many responsibilities other than IPC and ultimately rise to the challenge. However, the problem of “other duties as assigned” has been exacerbated by the

pandemic; nowhere is that more evident than in long-term care facilities. As we have noted in this column previously, nursing homes have been faced with IPC limitations for some time. Consumer advocacy and state and federal laws, as well as regulatory action, have hastened the focus on IPC in the acute care setting.

The pandemic has presented stark differences between IPC in nursing homes

and hospitals and has highlighted the need for change going forward. Existing nursing home IPC regulations must be enforced, and new requirements are needed, so that nursing home residents will not be placed at unnecessary risk.

Nursing home landscape

The population of nursing homes has changed drastically over recent years.

There are currently 1.3 to 1.8 million people residing in nursing homes in the U.S. This number is only expected to grow with the aging population of Americans. By 2030, it is expected that the nursing home population will explode to a whopping 5.3 million residents. This is due in part to the population skewing older than before, but also has to do with increased life expectancy. Increased life expectancy can mean an increase in health challenges that may require complicated drug regimens, complex medical equipment, and invasive devices. These factors put nursing home residents at a higher risk for infection. This issue is compounded by an inadequate regulatory environment and an industry that consistently cites resource limitations when calls are made for IPC improvements.

Another issue that compounds the stress placed on IPs in nursing homes is the high staff turnover rate. The turnover rate of certified nursing assistants (CNA) can range from 55 to 75 percent and can get as high as 100 percent. This means IPs are spending less time managing IPC programs and more time educating new hires. Turnover is not just limited to the CNA workforce, and extends to registered nurses, licensed practical nurses, and even IPs themselves. This severely stresses the institutional knowledge in a facility, which can lead to difficulties providing a consistent, safe, and standardized level of care for residents.

While the residents of nursing homes are highly susceptible to infection due to age-related comorbidities, inadequate IPC practices can also create a hazardous work environment. The pandemic has only heightened this pre-existing dilemma. In fact, CMS and the Bureau of Labor Statistics labeled nursing in long-term care facilities as one of the deadliest jobs of 2020. According to the Kaiser Health News, just through the end of 2020 approximately 570,000 healthcare workers contracted COVID-19, resulting in 2,900 deaths. “Lost on the Frontline,” an investigation by *The Guardian* and Kaiser Health News, found that twice as many nursing home workers died as hospital workers.¹ Long-term care facilities were even more short-staffed than normal

because employees became infected or were afraid of becoming infected with COVID-19. With a strained workforce and a raging pandemic, some states called in the National Guard.

The IP landscape in nursing homes

These challenges can be enough to strain IPC programs with unlimited resources. Unfortunately, there is substantial evidence that IPC programs in nursing homes are low on the priority list. According to the APIC MegaSurvey, the average IP working in these facilities spends about a third of their time working on IPC priorities. These IPs are often forced to wear “many different hats” and are not able to focus on IPC, but instead are diverted to assist with the urgencies of the day. This lack of commitment to IPC is further highlighted by the fact that from 2014–2018, for-profit nursing homes reduced their IPC resources.²

While IPs in nursing homes are committed to IPC for their residents, the resources needed for recruitment and education are often lacking. APIC members have expressed concerns that it is fairly common for individuals to be assigned or “volunteered” to fill infection prevention positions in nursing homes without prior experience or interest in IPC. While these IPs are no doubt committed to keeping residents safe, this is just another example of the lack of prioritization for IPC programs. Additionally, only 10 percent of IPs are certified in infection control. Unfortunately, this lack of prioritization and specialization puts residents in harm’s way not only during a pandemic, but also in the constant battle nursing homes face against healthcare-associated infections.

APIC’s strategy

Unfortunately, history has shown that, unless infection control measures are required through statute, it is very difficult to get facilities to act. As a result, APIC is working with legislators and regulators to update IPC practices in nursing homes. APIC’s recommendations for nursing homes are as follows:

- Every facility must employ one full-time on-site IP.

A CALL TO ADVOCACY

At the end of the day, legislators would prefer to hear from their constituents than organizations. They want to know what your concerns are and how they can help you. If this is an issue you care about, we need you to tell those in power. COVID-19 has given way to a rise in virtual advocacy, which in many respects makes it easier to get in contact with your representatives. APIC wants to make contacting legislators as straightforward as possible. If you wish to set up a meeting with a legislator, reach out to us at legislation@apic.org. We will schedule the meeting, give you talking points, and join you on the call.

If you are not quite ready to connect with legislators in person, we also have the APIC Action Center. The Action Center provides you with letters that auto-populate with your representative’s information and can be customized to convey personalized messaging. The topics range from masking, to supporting vaccination efforts, to encouraging legislators to attend educational events. Getting involved in your local government is crucial to moving improvements forward in the field of IPC. To learn more about the Action Center, visit <https://cqrcengage.com/apic/action-center>.

- All IPs in facilities must be certified.
- All facilities must create a surveillance plan to monitor high-risk infections.

This effort is currently being piloted in New York State and the proposal has been discussed with members of Congress. Due to the toll COVID-19 has taken on nursing homes, IPC is center stage and IPs need to be recognized as essential to these efforts. **P**

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

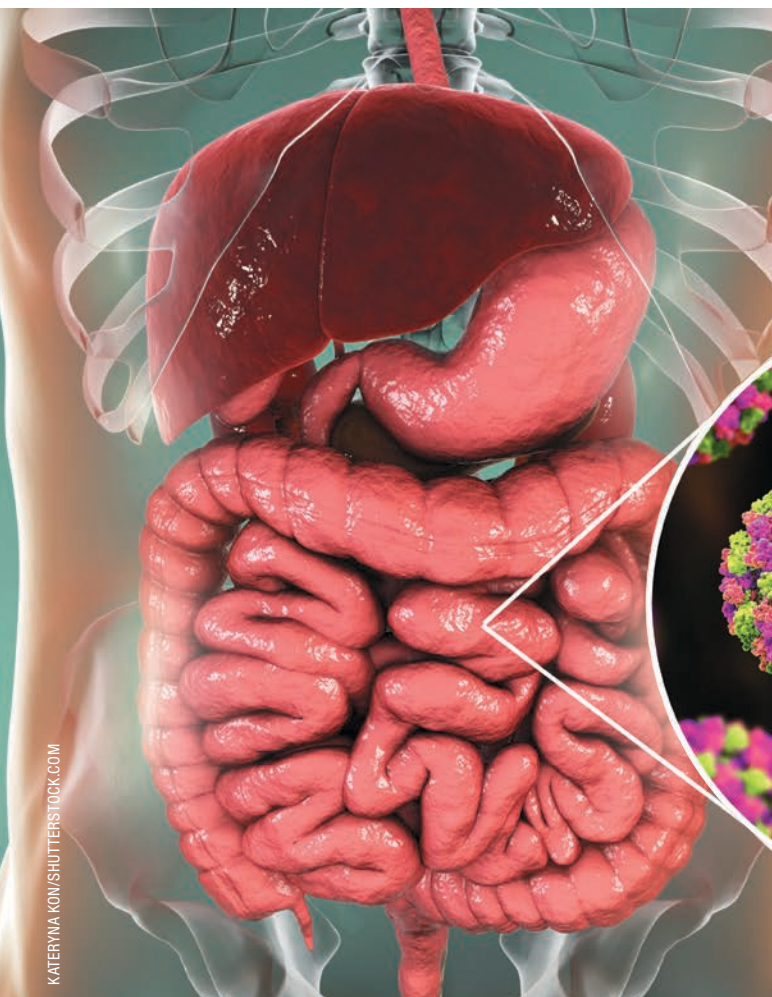
Focus on long-term care and behavioral health outbreaks

Identify the pathogen!

BY STEVEN SCHWEON AND TAMMY WOLFRAM

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 help prevent future infections and infection clusters in their facilities. This quarterly column helps the IP heighten awareness of appropriate interventions to prevent outbreaks.

Gordon et al¹ described a gastroenteritis outbreak that occurred in a retirement community in the San Francisco Bay area during spring 1988 and was reported to public health officials. This retirement community housed 362 residents in a 25-story facility. There were 311 residents who either lived alone or had roommates (did not require scheduled care provided by the retirement community). Eleven residents required round-the-clock supervision and lived in private rooms, while the remaining 40 residents resided in the skilled nursing facility. Approximately 120 full-time employees, including nurses, nursing assistants, dietary, office, and house-keeping personnel, worked at the facility.



The attack rate was 46% for the residents and 37% for the employees. Two residents died. Symptoms were nausea, vomiting, and diarrhea. Microbiological testing was performed on the stools of one of the ill residents in addition to electron microscopy (EM) and acute and convalescent-phase serum specimens. Illness was associated with both ingesting a shrimp meal and person-to-person transmission during a 3.5 week period.

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

1. *Clostridioides difficile*
2. *E.coli* O157:H7
3. *Staphylococcus aureus*
4. Snow Mountain Agent

All resident meals were prepared in one kitchen at the facility. Approximately 1,000 meals were prepared daily for the residents, and 700 to 1,000 meals were prepared for distribution to 15 other elderly residential facilities. Hot and cold sandwiches, prepared by a different kitchen, were available for the staff to purchase.

The *case definition* for the investigation into the gastroenteritis was defined as an acute onset of vomiting or diarrhea (two or more stools per 24 hours), or both, in any resident or staff, during the 3.5-week outbreak period. Using this case definition, the attack rate for residents was 46% (155/336), with 37% of employees (28 of the 75) becoming ill. Gastroenteritis contributed to the death of two residents. Three residents sustained injuries (two scalp lacerations and one broken toe) after falling due to near-syncope episodes caused by dehydration. Due to prolonged outbreak, resident-to-resident transmission occurred, including residents who shared apartments.

Stool specimens obtained at the outbreak onset were negative for *Salmonella*, *Shigella*, *Campylobacter*, *Vibrio* spp., enterotoxin-producing *E. coli*., ova, or parasites.

Laboratory tests used during this outbreak included EM and enzyme immunoassays (EIA). Snow Mountain antigen was identified in the stools.

Snow Mountain Virus (SMV) is a 27-nm RNA norovirus, Genotype II

TAKE-HOME MESSAGES

1. Adhere to your federal, state, and local regulations, in addition to facility policy, when an outbreak is suspected; consider developing an outbreak policy, which includes key contact, including the daily and after hours phone numbers of the appropriate health department.
2. Presenteeism (when an employee goes to work, despite having signs and symptoms of an illness) is well described in the literature.⁶ The CDC promotes the use of flexible, non-punitive sick leave policies to prevent individuals with communicable diseases from coming to work.⁷ Collaborate with the health department when a food service worker, with a communicable disease, is cleared and may return to work.
3. Foodborne disease outbreaks are a national notifiable condition to public health authorities.⁸ Have an awareness of what your local process is (e.g., electronic, fax, etc). Consider storing the health department's contact information in your personal phone and computer.
4. Symptomatic residents may need to be separated from healthy roommates. Visitation may need to be curtailed.
5. Ensure environmental services are aware of the need to use a disinfectant that is effective against norovirus.
6. After completing resident care, teach staff to use soap and water and not the alcohol-based hand sanitizer after removing personal protective equipment.

belonging to the family Calciviridae. It was first identified during an outbreak at Snow Mountain, Colorado, in 1976.² Genotype I norovirus is formerly known as Norwalk agent and was identified in 1968 during an outbreak involving elementary students in Norwalk, Ohio.

Conventional Reverse Transcriptase (RT)—Polymerase Chain Reaction (PCR) is the gold standard for detection and typing.³ The most sensitive test used today is Real Time (RT)—PCR using unpreserved stool. The test detects both Genotype I and II. A newer test available is a Multiplex RT-PCR method that detects 22 gastrointestinal pathogens, including bacteria, viruses, and parasites. This allows for faster detection, treatment, and infection control interventions.

The median incubation period for norovirus is 1 to 2 days, and can be as early as 12 hours.^{3,4} The most common symptoms are diarrhea and vomiting. A low percentage of patients may experience abdominal pain (4.4%) and fever (2.2%).² Symptoms last from 1 to 3 days.^{3,4}

The Centers for Disease Control and Prevention (CDC) has published recommendations with managing norovirus outbreaks.⁵ Key recommendations include:

- Avoiding exposure to vomitus or diarrhea to prevent transmission
- Placing patients on contact precautions in a single room, for a minimum of 48 hours after symptom resolution
- Closing wards and avoiding transferring patients may be necessary
- Washing hands with soap and water to prevent transmission after caring for or having contact with norovirus patients
- Using a 60% to 95% ethanol-based hand-sanitizer for hand hygiene prior to caring for patients
- Cleaning and disinfecting patient rooms and surfaces using products with activity against norovirus, which are listed on the Environmental Protective Agency (EPA) List G.⁵

Treatment is supportive to prevent dehydration and maintain electrolyte balance. Antiemetics or antimotility agents may be beneficial. There is currently no anti-viral medication or vaccine available.

The Department of Health investigators used written questionnaires when interviewing the residents and staff. Information included age, sex, resident-location, employee occupation, food exposure, water consumption, hand-washing practices, and exposure to residents' soiled laundry, stools, or vomitus. Kitchen staff were interviewed regarding

IDENTIFY THE PATHOGEN!

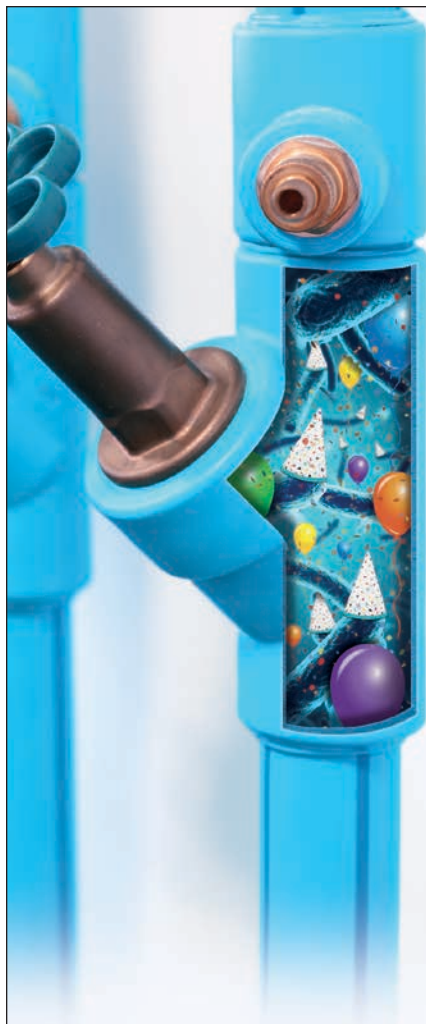
food-handling practices. Health department sanitarians visited the facility kitchen and identified no deficiencies. None of the 15 residential facilities who additionally received prepared meals from the kitchen reported gastrointestinal illness among the residents and staff.

Shrimp Louis and Shrimp Seafood Newburg, served before the gastroenteritis developed, was identified as a risk

factor for illness. Investigators focused on the shrimp preparation and felt all processes were adequate. The food preparer for both shrimp dishes denied any gastroenteritis history.

The investigators suggested a common source, i.e., shrimp, and subsequent person-to-person transmission, as the cause. Possible sources responsible for the outbreak include:

- The shrimp, prior to arrival at the kitchen. This was discounted after noting this food product was steam-cooked, after being purchased frozen.
- There may have been an unidentified factor that was associated with illness in those who ingested the shrimp; however, no confounding variable was identified.
- The food handlers, despite denying gastrointestinal illness, may have been ill with a nonspecific illness or asymptomatic infection, resulting in food contamination during the thawing and preparation of the shrimp meals. **Ps**



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Steven J. Schweon, RN, MPH, MSN, CIC, 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.

Tammy L. Wolfram, MS, SM (ASCP), is a clinical microbiologist and instructor, specializing in laboratory testing and training.



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A conversation with an infection preventionist

William F. Brown, Jr.,
BSN, RN



WILLIAM IS AN Infection Preventionist at UCLA Health Ronald Reagan Medical Center. Prior to starting his career as an Infection Preventionist, William worked in a variety of nursing roles to include Intensive Care Nursing, Medical Surgical Nursing, and Nurse Practice Council President. In addition to nursing, William served as a Patient Safety Manager and Infection Control & Prevention Manager with the United States Army Medical Activity Japan.

1. What inspired you to become an Infection Preventionist?

I actually stumbled upon the profession after working as a registered nurse. When my spouse received a job transfer to Japan, I left my nursing job in Florida and searched for nursing jobs on the U.S. military bases upon arriving there. While interviewing for a Department of the Army Civilian nursing position, the interviewer thought that I would make a great fit for a new opportunity at their ambulatory medical facility. The new position was a dual role: Infection Prevention-Control and Patient Safety Manager. I subsequently accepted the position, serving for 5 years before starting my current role as an Infection Preventionist at UCLA Health Ronald Reagan Medical Center in Los Angeles, California.

2. What were some of your challenges when you first entered the field?

Since no one had ever served as an Infection Preventionist (IP) at my previous facility, I had the challenge of creating a program from the ground up. It was actually a great learning experience, and it gave me the ability to develop and implement infection prevention policies and educational resources, action plans, and new surveillance strategies.

3. What has helped you most as you have progressed in your role as an IP?

What has helped me most is having a network of other IPs to lean on. Early in

my career I learned the value of networking and was privileged to meet other IPs at APIC Annual Conference and Infection Prevention Summits. My network has been a great resource for guidance and mentoring as I continue to grow in this amazing profession.

4. How has your background helped you in the IPC profession?

My background as a registered nurse gave me a good foundation to build on as an IPC professional. As nurses we are trained to prevent the spread of diseases, practice standard precautions, understand disease processes, educate staff/patients, and work with a team of multidisciplinary healthcare professionals to implement patient safety initiatives, all of which are needed to be an effective IP.

5. Why is obtaining (or maintaining) the CIC credential important to you?

I have been studying for my CIC, which I hope to obtain by spring 2021. Obtaining the CIC certifications will further my capabilities, demonstrate commitment to the IPC profession, and validate my professional expertise.

6. What is the best advice you ever received?

The best advice I ever received is don't be afraid to reach out to others when you don't know the answer. Our profession is always changing and learning never ends. Reaching out to my internal and external IP colleagues has continued to help me navigate the challenges created by rapidly changing new guidance during the COVID-19 pandemic.

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

For those that are new to the career field, I would encourage you to cultivate

relationships with the people you work with daily. As an IP, you will work with a multidisciplinary team of healthcare professionals. Building and maintaining relationships with your team members will be vital to helping you meet your IPC objectives and goals.


8. Can you discuss how you work with other healthcare professionals in any given day?

I collaborate with a variety of committees to help meet IP and safety objectives. Committees include but are not limited to: Patient Safety, Antibiotic Stewardship, Infection Prevention, Environment of Care, Hospital Policy and Regulation, HAI Task Force Committees, and more. All committees members consist of healthcare professional that touch nearly every aspect of healthcare. In addition to committees, I work with laboratory, safety, nursing, patient safety, medicine, logistics, and environmental services professionals daily to provide consultation, investigate HAI's, develop policies, increase infection prevention compliance, and ongoing infection prevention education.

9. What would you recommend to a new IP looking to expand their network?

Get involved with your local APIC chapter, attend APIC conference, get to know the IP's from neighboring hospitals, and within your health system.

10. What's been a highlight of your career as an Infection Preventionist so far?

The highlight of my career has definitely been working with my IP colleagues at UCLA Health during the current pandemic. We have collaborated to develop education, procedures, and infection prevention measures to help ensure the safety of patients and staff during the COVID-19 pandemic. It is great to be a part of such a world class team! 



It's time to take proven infection prevention further

Figures released from the CDC make stark reading for Infection Preventionists. An estimated 722,000 healthcare-associated infections occur annually, resulting in 75,000 deaths and billions in additional costs.¹ More than half of these occurred outside of the intensive care unit.

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New Jersey Department of Health Executive Directive in response to the COVID-19 Pandemic

BY APIC CONSULTING SERVICES



BARBARA ST. JOHN, RN, BSN CIC, CRRN, has worked in infection prevention and control for more than 12 years, primarily in the acute care hospital and rehabilitation setting. She is an active member of the Northern New Jersey APIC Chapter and has recently served on the APIC Chapter Nomination Committee. In 2018, St. John began her own infection prevention consulting company, servicing ambulatory surgery centers seeking or maintaining licensure in New Jersey. In addition, she consults through APIC Consulting Services, providing guidance to long-term care, skilled nursing, and assisted-living facilities in response to the COVID-19 pandemic.

Can you tell us about the Executive Directive that the state of New Jersey implemented in August? What does it require of long-term care facilities?

In August 2020, the New Jersey Department of Health (DOH) published Executive Directive (ED) 20-026: Resumption of Services in all Long-Term Care (LTC) Facilities. This 45-page document outlined the requirements

for initiating phased reopening in LTC, assisted living, comprehensive personal care homes, residential care centers, and dementia care homes. The ED document includes guidance such as the following:

- Guidance related to the testing of employees and residents, taking into consideration the region's current positivity rate reported in the COVID-19 Activity Level Index Weekly Report.
- Core infection prevention and control practices must be in place, including specific requirements for long-term care facilities with a certain number of beds and those that care for residents on ventilators.
- Facilities are required to report the amount of personal protective equipment (PPE) they have stockpiled, showing that they have adequate supply to meet the requirement.
- Depending on the reopening phase the facility is currently in, the directive outlines visitation and services that the facility is permitted to provide.
- Cohorting of residents, training of employees to correctly don and doff PPE, and considerations to special circumstances such as compassionate care and end-of-life visits are also addressed in this comprehensive document.

What are the trends that you see in the LTC facilities you have assisted throughout the state?

I have had the opportunity to work with compassionate, engaged employees in LTCs throughout the state of New Jersey. One of the trends I have identified is the challenge for staff to “keep up

with” changes surrounding COVID-19 guidance from the Centers for Disease Control and Prevention (CDC), World Health Organization, and New Jersey DOH. Another common challenge for LTC staff is implementing contact tracing procedures. Most recently, I have seen the need for further education around employee COVID-19 vaccination. It is important to define common reasons for declining the vaccine and to target education efforts accordingly.

What are three things the LTCs and related facilities should prioritize for their infection prevention and control programs?

Facilities should use the Three I's: **Interventions, Identification, and Isolation.**

Interventions: Staff should use basic infection prevention and control interventions to prevent infections and transmission. These measures include source control masking of employees in hospital grade surgical masks; masking residents when out of their rooms (if they can tolerate it); hand hygiene before and after contact with a resident or their environment; and maintaining social distancing while dining, in charting areas, and in staff lounges.

Identification: Identification of employees or residents suspected of having COVID-19 is imperative to prevent outbreaks. Employees should self-monitor for symptoms consistent with COVID-19, and residents should be assessed regularly. Facilities need to follow a serial testing plan appropriate to the level of

COVID-19 activity in their area and to their current reopening phase.

Isolation: Prompt isolation of any suspected or confirmed positive COVID-19 resident within a facility will help prevent further transmission. It is important to have a clear process when a positive or suspected case is identified to allow for an organized and safe approach. This includes having a predetermined area to house confirmed and/or suspected positive COVID-19 residents. This area needs to remain at the ready, equipped with all necessary PPE and signage. Facilities should follow the CDC recommendations for the time-based discontinuation of COVID-19 isolation protocols.

As more people are vaccinated, should LTC facilities shift their focus to different priorities?

The current number of daily positive COVID-19 cases in New Jersey would suggest that we are not “out of the woods”


just yet. A great number of LTC residents have been vaccinated against COVID-19 as a result of a comprehensive vaccination program including large area pharmacy chains. Employees interviewed during my visits have voiced reluctance to the vaccine, mentioning fear of the unknown, wanting to wait for others to receive it first, and thinking the vaccine was created too quickly to be safe. When considering this reluctance, the emerging pathogens, and the unknown duration of immunity from the vaccine, I would not suggest shifting priorities just yet. That being said, I am in agreement with resuming visitation and taking steps to have LTC residents reunited with their loved ones.

If other states pursue a similar directive, what should they keep in mind?

First, states should consider that this pandemic is a fluid situation and that they must readily adapt to change. What

is an appropriate direction today may not be tomorrow. As the scientific community learns more about this virus, policies and procedures will continue to need updating.

Second, having evidence-based guidance allows for a standardized approach for facilities to follow. Many facilities are part of a larger health system, and it is helpful for all facilities to receive the same directives under similar conditions. If an employee works at more than one facility, they would react the same in a similar situation regardless of the facility. I have never been one to “reinvent the wheel,” so if I have an opportunity to use a state-sponsored website to find the latest guidelines with rationales to address common questions and concerns, I am going to use them. I would encourage other states to do the same.

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Survey visit tips and more from The Joint Commission

BY SYLVIA GARCIA-HOUCHINS, WITH ELIZABETH HABERKORN



Sylvia Garcia-Houchins, MBA, RN, CIC

SYLVIA GARCIA-HOUCHINS, MBA, RN, CIC, director of infection prevention and control (IPC) at The Joint Commission, may not have all the answers when it comes to COVID-19, but she does offer advice to other infection control preventionists (IPs) on how to run a successful organization. “Give IPC data back to leadership,” she said. But that, she notes, is not always as easy as it may sound. IPs have very specific training, so the terminology they use may not be common to other healthcare professionals. Garcia-Houchins, now in her third year as director of IPC at The Joint Commission, realized this when trying to explain to colleagues about universal masking. “People didn’t know what I was talking about when I spoke about source control. I have been doing this for 30 years, so I automatically jumped into my IP lingo, but learned pretty quickly that I needed to step back and simplify the information,” Garcia-Houchins said.

“I needed to explain as if I was speaking to my mother. I needed to review how I was sending the message and if that could be a reason why I felt that I wasn’t being heard.”

It is a challenge that The Joint Commission experiences, too: getting the word—the correct word—out to IPs. “It can be similar to a game of Telephone,” Garcia-Houchins said. “Instead of asking The Joint Commission directly, someone hears incorrect information from someone else, and believes it to be true. The issue of hangtime of endoscopes is a perfect example. The Joint Commission does not have a standard that requires healthcare organizations to specify a hang-time for endoscopes, however many health professions erroneously believe we do.” Communicating with organizations is part of the challenge that comes with the job she now holds; delivering IPC information to people on the frontlines can be challenging even while utilizing *Perspectives*, the official newsletter of The Joint Commission, and platforms like presentations and speaking engagements, such as their “Dispelling the Myths” webinar replay on disinfection and sterilization, available at www.jointcommission.org/resources/patient-safety-topics, under the Infection Prevention and Control section.

Preparing for surveys

Another challenge The Joint Commission experiences is overall survey perception. Garcia-Houchins wants IPs to understand that Joint Commission surveyors are not inspectors but collaborators. “Preparing for a Joint Commission survey is not

personal. It is about the organization, not the IP,” Garcia-Houchins said. “And the infection control program must be facility-wide, so leadership needs to provide help and information to the IP. But the IP also needs to ask for help when needed. IPs need to follow a systematic approach to ensuring that they are providing sound IPC direction for their organization.”

Perfect is the enemy of good, Garcia-Houchins believes. “Sometimes IPs are so concerned with making the process or intervention perfect that there are delays to interventions that are good enough to start preventing infections and saving lives.” Following the hierarchical approach to ensuring compliance to IPC standards can be found in the April 2019 edition of *Perspectives* and is a good start to making sure an organization is implementing at least the basics.

There are several directions Garcia-Houchins wants to give to IPs regarding a survey visit: Follow the hierarchy that can be found in April 2019 *Perspectives*; if you don’t understand why a surveyor is questioning an IPC practice, explain your rationale to leadership or, if given the opportunity, the surveyor; if you don’t agree with a finding discuss it with the individual surveyor or ask your organization’s “survey manager” to use the time set aside for issue resolution with the surveyor; and provide the IPC perspective of the situation as well as any relevant documentation before the surveyor leaves. After survey, there is a clarification period, but organizations can only ask for clarification if there is an issue with the survey process or if a mistake has been made during survey.

Organizations cannot provide documents during the clarification period that should have been provided to the surveyor for evaluation and discussion while he or she is on site.

Facilitators for change

If there are IPC issues identified during survey, IPs are the facilitators for change. Many times, they need staff to help understand the intricacies of the situation, Garcia-Houchins said. “IPs need to work with staff, to understand why they are not doing what policy says or what the IP thinks they should be doing. It is imperative to understand the why before fixing the what. Sometimes the issue is unsafe practices but sometimes the issue is the wrong process or procedure. Take the time to find the root cause for a survey finding.”

It is important to remember that a survey by The Joint Commission is a collaborative effort but sometimes the IP is not allowed to participate or is not invited to a particular meeting with the surveyor. And, some IPs have interpreted this to mean that the surveyor does not want to speak with the IP. Of the notion that the surveyor does not want to speak to the IP, Garcia-Houchins believes this is another misconception. It may be that the surveyor wants a particular staff member to answer questions as part of their assessment and asks the IP not to answer so that they assess the situation correctly. Surveyors do not determine who can speak with them or attend survey meetings—the organization does. If there is an IPC-related issue, “once the IP gets pulled into the conversation, the issue usually gets resolved,” she said.

As a prior healthcare consultant, Garcia-Houchins has found sometimes not being included in the survey process is about the relationship the IP has with the organization’s accreditation staff or leadership. It is always a good idea for the IP to have a good working relationship with the organization’s accreditation manager and leadership before survey. The value an IP can bring to the survey process needs to be known because

all geographic locations and care, treatments, and services provided have to be included in the IPC assessment and plan. For this reason, most of the time IPs are incredibly knowledgeable about the entire organization and that can be a big asset during survey.

‘Don’t lose sight’

The COVID-19 pandemic has altered IPC-related priorities for reasons that may be unique to an organization, for example, due to their physical layout or because of the more common challenge of providing care for multiple COVID-19 patients while conserving personal protective equipment. And as lessons are learned from this past flu season, IPs are recognizing that the COVID-19 interventions will also prevent flu transmission. “In the southern hemisphere, where they experience a flu season before the north, flu transmission was down considerably.¹ If they haven’t already, IPs need to ensure that their leadership is aware of the evolving science that universal masking for both staff and patients can decrease risk of transmission of other respiratory viruses. Social distancing is an ‘and’ and not an ‘or.’”

IPs need to use what they know about transmission to identify situations that need to be addressed before they turn into outbreaks. In addition, Garcia-Houchins reminds IPs, “don’t lose sight of the major strides we’ve made in decreasing the transmission of other organisms that cause healthcare-associated infections, like pneumonia and central line-associated bloodstream infection. We need to remember that altered infection control practices, like extended use of gowns in cohort situations or failure to perform oral care because of concern that it could create aerosols, could lead to the spread of multi-drug resistant organisms or increased incidence of infection amongst patients.” IPs should be looking for situations and trends that indicate cross transmission or an increase in potentially preventable infections. If this happens, IPs should work with leadership and staff to identify and implement interventions.

Innovation

“IPs have been innovative during COVID-19 and we need to harness that information to figure out what is safe, what is not, and be systematic and use that knowledge to develop our science,” Garcia-Houchins said. That may be easy for her to say, as innovation comes naturally to her. Over her career, she has found innovative ways to prove that transmission of infection could be stopped by simple and low-cost interventions—like disinfecting the “o-ring” as a step during reprocessing hemodialyzers to prevent bloodstream infection.²

Garcia-Houchins’ introduction to infection prevention and control came while working in the microbiology laboratory and helping to investigate an outbreak investigation of group A strep infection that looked like it had originated in the operating room. The infection control team suspected a circulating nurse was the source of the outbreak but had to figure out how to prove their suspicion. Garcia-Houchins placed the nurse in question in a large closet and stacked petri dishes on shelves from floor to ceiling, under the assumption that if the nurse was the source of patients’ infection, the organism would need to be able to contaminate most of the petri dishes. After the nurse walked back and forth in the closet for 20 minutes, all the petri dishes, even the one closest to the ceiling, tested positive!

Sometimes it takes persistence, but armed with sound information and the right approach, leadership and staff will eventually be ready to listen to IPs who are proven leaders. **PS**

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Sylvia Garcia-Houchins, MBA, RN, CIC, is director of infection prevention and control at The Joint Commission.

Safeguarding the Patient Environment

Through Enhanced Infection Protocols with Electrostatic Technology

Healthcare facilities face numerous challenges when it comes to maintaining the safety of the patient environment, especially amidst a pandemic.

From urgent threats like SARS-CoV-2, the virus that causes COVID-19, to common infection-causing viruses like influenza to multi-drug resistant organisms (MDROs) to healthcare-associated infections (HAIs) like *Clostridium difficile* (*C. difficile*), there are innumerable opportunities for patients' well-being to be put at risk. As a result, healthcare facilities need a comprehensive approach to infection control to help maintain patient and worker safety.

THE CHALLENGE: MAINTAINING THE SAFETY OF THE PATIENT ENVIRONMENT AGAINST THE SPREAD OF INFECTIONS

Disinfecting surfaces in hospitals is challenging and time-consuming work, and no matter how meticulous Environmental Service (EVS) teams are some pathogens can still resist or hide out in hard-to-reach places.

In fact, research suggests only 50 percent of surfaces in patient

rooms and operating rooms are effectively disinfected.^[i]

Proper disinfection of portable and shared medical equipment is also an important component of infection prevention as this equipment frequently becomes contaminated and often has irregular and difficult-to-clean surfaces.

THE SOLUTION: ADDING AN EXTRA LAYER OF CONFIDENCE WITH ELECTROSTATIC TECHNOLOGY

A recent study published in the *American Journal of Infection Control* showed how The Louis Stokes Cleveland Veterans Affairs Medical Center, a 215-bed acute care facility, used the Clorox® Total 360® System to help decontaminate portable equipment and waiting rooms, achieving statistically significant reductions ($p \leq .01$) of pathogens including *C. difficile*.

Use of Clorox Healthcare® Spore Defense™ Cleaner Disinfectant through the Clorox® Total 360® System proved to be as effective as bleach wipes in reducing *C. difficile* spores on wheelchairs, but could be applied in one-fourth of the time, providing healthcare facilities with a rapid and effective means to reduce spore contamination on surfaces like never before.^[ii]

The Clorox® Total 360® electrostatic sprayer works by charging and atomizing Spore Defense, delivering a powerful flow of charged particles that are attracted to surfaces with a force stronger than gravity.

IMPLEMENTATION: EXECUTING ELECTROSTATIC TECHNOLOGY

By supplementing manual cleaning and disinfection practices with electrostatic technology, facilities can offer an extra layer of confidence by killing microorganisms in areas that may otherwise be missed. With broad surface compatibility, low residue profile, 43 pathogen kill claims and low odor, Spore Defense is easily implementable for facility-wide use. Spore Defense is also EPA-approved for use against SARS-CoV-2.

“When it comes to the cleaning and disinfection of shared and portable medical equipment such as wheelchairs and gurneys, thoroughness of cleaning is often suboptimal and application can be challenging and time-consuming,” said Curtis Donskey, MD, Infectious Disease Specialist. “This is what makes the development of this sporicidal solution and its ability to be used with electrostatic technology a substantial innovation — it helps provide a solution for healthcare facilities that wasn’t previously possible.”



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10 *Clostridium difficile* spores only

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AJIC author interview: Teena Chopra

BY PATRICIA STONE



PATRICIA STONE, PHD, RN, FAAN, AJIC editor in chief, interviewed the author of the upcoming AJIC article, “A laboratory model demonstrating the protective effects of surgical masks, face shields, and a combination of both in a speaking simulation.” doi: 10.1016/j.ajic.2021.01.012

As a woman epidemiologist I want to take this opportunity to inspire other women to pursue leadership roles and not be afraid to be in charge. Women leaders are more compassionate and risk averse and it's so important to inspire young women. –Teena Chopra, MD, MPH

Teena Chopra is a Professor of Medicine in the Division of Infectious Diseases, at Wayne State University and the Corporate Medical Director of Hospital Epidemiology, Infection Prevention and Antibiotic Stewardship at Detroit Medical Center, Wayne State University. Her research interests include Epidemiology of Health care associated Infections, Infection Prevention Antibiotic Stewardship and Immunization.

Dr. Chopra has published over 80 papers in various journals and book chapters. Additionally, she has independently reviewed over 60 journal articles. Dr. Chopra has a special interest in immunization and studying the epidemiology of infections, including *Clostridium difficile* and Multi-Drug Resistant Organisms. Dr. Chopra has championed the mammoth task of leading the COVID-19 pandemic for Wayne State University and DMC. She is serving on the president's COVID task force and on the President's Public health committee. She has appeared on countless media and print interviews including CNN, FOX, NPR and TIME magazine.

What are the circumstances that have led up to your current work?

My grandfather was a clinician and public health officer in India. I grew up hearing about his heroic service to the community during the Cholera epidemic in India. Once I came to Detroit for my training, I was fortunate to have been trained by great mentors like Dr. Jack Sobel who further sparked my interest in pursuing infectious diseases. During my training I was drawn to clinical epidemiology and infection prevention which allows me to apply my training in infectious diseases and affect change in the community. I loved serving the Detroit community and decided to stay.

In my position as the Chief of Fellowship in Infection Prevention and Hospital Epidemiology, I am responsible for all the training and educational activities for all the fellows, residents, and students who rotate through the program. I mentor junior faculty, fellows, residents, and students in developing scholarly activities and hospital infection control and quality improvement projects including national presentations, publications, and obtaining grants. At the medical school level, I am leading the effort

in conceptualizing, designing, and implementing the medical students' Infectious Diseases Interest Group in collaboration with the Infectious Diseases Society of America for the last 2 years.

In my role as the Corporate Medical Director of Infection Prevention, Hospital Epidemiology and Antibiotic Stewardship at DMC and Vibra Hospital, I am responsible for drafting Infection control policies and procedures for eight hospitals across metro Detroit area. I have led my hospital through several outbreaks including H1N1, Measles, Hepatitis A, and currently the COVID-19 pandemic.

In my role as Professor of Infectious Diseases, I am heavily involved in inpatient clinical rounding and teaching and mentoring residents, fellows, and junior faculty. I am currently training a junior faculty in infection prevention and hospital epidemiology so she can eventually transition into my role as I assume more university level leadership role in the future.

In my role as a research scientist, I help improve patient quality by decreasing healthcare-associated infections (HAIs) through application of evidence-based processes, innovation, good stewardship of available resources, and technology.

In my role as the public health expert for the university, I help the president

with pandemic response including drafting policies, shutdown and restart metrics, testing, and vaccination campaign.

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

My focus has always been my patients. The underserved patients of Detroit represent a unique population with a myriad of challenges and barriers to health. These disparities contribute to the presence of multi-drug resistant organisms which continues to be a problem to this day.

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

Infection prevention and antibiotic stewardship are extremely important in this day and age where we are faced with a huge public health crisis. HAIs and antibiotic resistance have been rising at an alarming rate and its very important to have experts in this field in every healthcare center and in every clinic who see patients. We have to do a better job at preventing infections to overcome future crises like COVID-19.

Describe the day when you discovered a major impediment to infection prevention.

Until now, a major impediment to infection prevention is lack of enough support in the form of funding and personnel in this field. We need to make sure we have one infection preventionist for every 100 beds in the hospital. We need to make sure we have infection preventionists overseeing infection prevention in the ambulatory setting, nursing home setting, rehabilitation centers, dialysis centers, and every post-acute care center. Currently this is not happening and we saw how this led to poor outcomes of COVID-19 patients in nursing homes as an example. Not every nursing home in the country has a trained infection preventionist overseeing their infection rates, hand hygiene rates, and other aspects of infection prevention. Hospital epidemiologists like myself need more support in the form of time commitment

to do our jobs. More funding needs to be allocated to Infection prevention and hospital epidemiology.

What is your favorite aspect of your work?

My favorite aspect is being able to work closely with different groups of individuals. Having multiple roles provides richness of experience that helps fulfill other roles—be it an academician, a clinician, an educator, a community leader, and a mother.

What is the coolest thing about your work?

I would say mentoring. Wayne State University is one of the largest urban universities and the only university in the city of Detroit. Ever since I came from India to practice medicine, I've been at this university. I did both my residency and fellowship here, and I also did a fellowship in infection prevention in hospital epidemiology and antibiotic stewardship here. In addition to that, I received a Master's in Public Health here—it's like a second home to me. Students come from all over the nation, and they're all extremely inspired to do research. They are basically the cornerstones for us mentors because we are inspired by them. Particularly during the pandemic, I have found that students are even more interested in the field of epidemiology and public health. I have seen more students requesting to do infectious disease electives and research electives with us now than before.

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

I have been leading the COVID-19 response in the Detroit Medical Center and also serving on the Wayne State University President's COVID-19 Task Force. Although there is currently another surge in Michigan, there has been significant success in controlling the outbreak particularly with regards to identifying nursing homes as hotspots and targeting these points by proper cohorting. Additionally, we have done an incredible job in vaccinating and helping educate the community on vaccination.



AVAILABLE IN AJIC

A laboratory model demonstrating the protective effects of surgical masks, face shields, and a combination of both in a speaking simulation. *American Journal of Infection Control*. 2021;(49):409-415. Published January 20, 2021. Salimnia H., Meyer M.P., Mitchell R., et al.

What do you want to achieve with your work?

I want to be able to continue to affect change and inspire others to take on more leadership roles, particularly women. It's important to continue to push on and move forward and empower others and share tools that might help others succeed.

In the media, Detroit has been mentioned as an area in where minorities are underserved in obtaining COVID-19 vaccines. As someone who has a “boots on the ground” view, what are your thoughts on the vaccine inequity situation in Detroit?


We are in the midst of a major surge in Michigan. The COVID-19 patients we are seeing in Detroit are either unvaccinated or have only received 1 dose of the vaccine. This tells you how the most vulnerable patients are still not vaccinated and are suffering from COVID-19 and will continue to deal with COVID-19 complications in the future.

When I am not working, I am spending time with Simran (my 7-year-old daughter) who wants to be a teacher and an infectious diseases physician when she grows up. The pandemic has inspired her to pursue this field and I hope more girls plan to pursue STEM fields in the future.

To read Chopra's article, go to www.apic.org. You must be a current member of APIC to access AJIC articles. P3

Patricia Stone, PHD, RN, FAAN, is AJIC editor in chief.

“Focusing on you”: Using the Proficient Practitioner Bridge to grow as an IP

A small white flower with green leaves growing out of dark, rich soil. The flower is in the foreground, slightly to the right of the center. The soil is dark and textured, with some small pebbles and organic matter visible. The background is a dark, out-of-focus grey.

BY CHRIS ZIRGES AND HEATHER BERNARD



BRADLEY DENNEN/SHUTTERSTOCK.COM

IPs across the world have been positioned front and center during the pandemic response. Today, it is more important than ever that IPs reflect on this past year, both personally and professionally. We invite IPs to assess their competency levels and needs so that they may move forward.

First identified in December 2019, the COVID-19 pandemic is one of the deadliest pandemics in history. A significant impact has not only occurred on the political, economic, and social aspects of our lives, but an emerging area of focus has been the impact on the mental health of healthcare professionals (HCPs).¹ The length of time we will endure this current crisis along with the disruption to normalcy is still unknown, yet the ongoing response requires HCPs to remain in a constant state of readiness.² This places HCPs in a high-stress situation over a long period of time.

Whether HCPs experience a positive or negative psychological impact related to this event may depend not only on external support systems but internal reserve or resilience. Stoffel and Cain³ noted that themes related to resilience and grit are increasing in the professional practice literature. While used interchangeably, there are differences between these two terms: grit is the sustained commitment in completing specific goals when confronted with barriers or setbacks, whereby resilience is the ability to recover from the stressors or setbacks and continue with the desired goal.³ Likewise, this pandemic has required HCPs to tend to the physical, emotional, and spiritual needs of others all while experiencing the same stressors.⁴

While the term “healthcare professional” is broad, the IP plays a lead role, on the front line, in the efforts to prevent healthcare-associated infections⁵ and as such has played a key role in this ongoing pandemic. Pre-pandemic, there was a need for complex environments to have an expanded IP practice.⁶ Professional backgrounds and academic preparation within the field are increasingly varied and now include laboratory and public health professionals.⁶ In response to these changing dynamics, an updated competency model was designed, APIC’s Competency Model

to Guide IP Practice, which includes Certification Board of Infection Control and Epidemiology, Inc. (CBIC) core competencies and the APIC Professional and Practice Standards, with the objective to prepare the IP for progressing through the career stages and pursuing leadership goals. See <https://apic.org/professional-practice/infection-preventionist-ip-competency-model/> for further details.

After experiencing the demands of a sustained pandemic, responding to ongoing guideline updates, and supporting the needs of clinicians and leaders, how might an IP now view their own resilience and describe their level of competency? Competency facilitates professional development beyond the basic skill set while at the same time advances knowledge and interpersonal decision-making skills.⁵ To support this endeavor, an online, interactive self-assessment tool called the APIC Proficient Practitioner Bridge is available to support IP growth and development for the IP in the proficient career stage. While aligned with the APIC Competency Model to Guide IP Practice, a development plan can be customized to the individual (see <https://apic.org/Professional-Practice/roadmap/PPB/> for more information).⁵


This pandemic has resulted in the most experienced IPs stretching their professional competencies and perhaps even questioning their own decision-making and leadership skills in this unprecedented time. An example is the development of reuse of personal protective equipment protocols during supply shortages; IPs have managed to gain the trust of leaders and clinicians while asking them to practice what is counterintuitive to standard, pre-pandemic policy. Resilience is an innate trait, basically the physiological and psychological makeup of the individual.⁴ Assessing or even re-assessing one’s skills and professional development goals

with the use of the Proficient Practitioner Bridge may foster greater confidence in the role and provide clarity with one's personal goals and learning needs.

The Proficient Practitioner Bridge can be completed online and allows for self-assessment in the areas of the future-oriented competency domains beyond the core competencies laid out by CBIC. For each of the six future-oriented domains, there are several subdomains where an IP can assess their knowledge base. Upon completion of the assessment, there is an option for a printable report with a score rating confidence level in each future-oriented domain. The report will allow the individual to assess areas of weakness in the future-oriented domains and subdomains by comparing the scores for each.

This tool has been used to help IPs develop professional development plans in the domains and subdomains that score

the lowest. One can develop a specific plan by identifying activities that would increase competency for that specific domain that scored lower than others. The Proficient Practitioner Bridge can be used by the sole IP with a desire to grow professionally as well as within an IP department with several IPs as an assessment tool of competency during evaluation periods.

There is not a better time than now to focus on you, advance your competency in the areas identified as opportunities, and develop an individualized growth plan. The Proficient Practitioner Bridge is an excellent tool to start this journey of growth and resilience. 

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Chris Zirges, DNP, APRN-BC, CIC, FAPIC, and Heather Bernard, DNP, RN, CIC, FAPIC, are members of APIC's Professional Development Committee.

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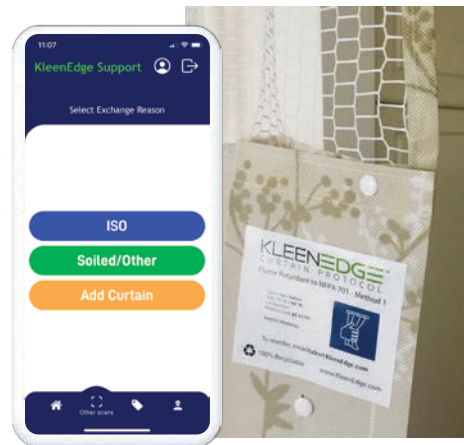
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Call for equity, diversity, and inclusion

BY SHAUNTÉ C. WALTON



**“The secret of change is to focus all of your energy not on fighting the old, but on building the new.”
—Socrates**

The nation continues to experience the effects of the twin pandemics of systemic racism and COVID-19. Social disruption due to racial injustice reached its pinnacle after the murder of George Floyd in 2020 and the COVID-19 pandemic magnified healthcare disparities that exist in vulnerable populations. Often challenges of this nature arise, but rarely are the solutions sustainable. Could this time be different? Recent events revealed a need to conduct organizational assessments to understand the effectiveness of equity, diversity, and inclusion (EDI) programs. Many healthcare organizations have a renewed urgency to address systemic inequity within the workplace and in the clinical setting. However, it is critically important to define what it means to be an equitable, diverse and inclusive organization as a foundation to championing change.

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UCLA health workers come together for the Black Lives Matter movement.



For the purpose of this article, we will use the definitions provided by The Independent Sector:

DEFINITIONS

Diversity includes all the ways in which people differ, encompassing the different characteristics that make one individual or group different from another. While diversity is often used in reference to race, ethnicity, and gender, we embrace a broader definition of diversity that also includes age, national origin, religion, disability, sexual orientation, socioeconomic status, education, marital status, language, and physical appearance. Our definition also includes diversity of thought: ideas, perspectives, and values. We also recognize that individuals affiliate with multiple identities.

Equity is the fair treatment, access, opportunity, and advancement for all people, while at the same time striving to identify and eliminate barriers that have prevented the full participation of some groups. Improving equity involves increasing justice and fairness within the procedures and processes of institutions or systems, as well as in their distribution of resources. Tackling equity issues

requires an understanding of the root causes of outcome disparities within our society.

Inclusion is the act of creating environments in which any individual or group can be and feel welcomed, respected, supported, and valued to fully participate. An inclusive and welcoming climate embraces differences and offers respect in words and actions for all people. It's important to note that while an inclusive group is by definition diverse, a diverse group isn't always inclusive. Increasingly, recognition of unconscious or 'implicit bias' helps organizations to be deliberate about addressing issues of inclusivity.

With basic knowledge of what EDI means, let's consider how we as infection preventionists can contribute to this effort within our own professional environments. There are four critical first steps to building a strong and sustainable EDI program.

SPEAK UP

Begin by giving yourself permission to speak up. When inequities are observed, we must be empowered to acknowledge and voice concerns when we visualize activities that do not align with the mission and value of EDI progression. These conversations will be difficult to have because they

are deeply emotional. It is normal to fear misinterpretation of your expressions, risking further disengagement or additional divisiveness. However, thoughtful and intentional dialogue acknowledging various perspectives and problem solving is far more impactful than remaining silent. As Infection Preventionists, we are expected to raise awareness of healthcare-associated infections in forums where the stakes are high. We are fortunate that we have mastered a level of competency to hold conversations that require diplomacy and empathy. Delivering feedback and beginning discussions about EDI is no different. Seek guidance from EDI experts in order to create a safe space to engage in a meaningful way. Don't be afraid to share your own experiences as they can be leveraged to connect with others that wish to understand.

AWARENESS BEGINS WITH TRAINING

Training encourages self-reflection and helps individuals gain a deeper understanding of various forms of bias and the impact it has on others. There are several free resources available online; however, standardization of the tools used for training within your organization is important to level set knowledge. There may be many questions about EDI concepts and the value of establishing a program,



so it is essential to engage an EDI expert to help facilitate discussions.

Once dialogue begins, remain compassionate and sensitive to those engaging. Those who identify as Black, Indigenous and people of color (BIPOC) relive past and present traumas almost daily, most often managed away from the professional environment. Some of our colleagues may choose to share experiences in an effort to increase awareness. Some may not want to openly discuss because of the emotional pain that accompanies acknowledgement of those that do not wish to accept and celebrate our differences. Honor each individual's request based upon comfort level; however, continue to offer support to those interested in participating. Creating support groups for those who feel marginalized to build a sense of community and belonging while collaborating with the larger collective to support change is crucial for effectively maintaining safety within the organization.

IDENTIFY OPPORTUNITIES FOR EDI IMPROVEMENT

In order to set an organization-wide agenda, it is paramount to gain awareness of current state and track trends. Evaluating the organizational structure and creating a comparative analysis to reveal the types of diversity within groups will help identify initial action items. The

following questions can help gauge the culture of your institution with respect to Infection Prevention:

OPERATIONAL ASSESSMENT

- When recruiting infection prevention professionals, is the current organizational belief that only registered nurses are qualified to perform infection prevention roles/responsibilities and serve in a leadership capacity?
- What disciplines are represented on your infection prevention team?
- Is your infection prevention team culturally diverse? Evaluate your pool of applicants and compare with hired candidates. Do your results highlight the hiring manager's preference and/or unconscious bias within talent management?
- Does pay equity exist among infection prevention professionals with non-nursing degrees?

CLINICAL ASSESSMENT

- Are there EDI trends associated with patients with healthcare-associated infections?
- How many patients with healthcare-associated infections have language barriers impeding optimal care?
- Are patients assessed for infection prevention inequities by payor/payor status?

- What percentage of patients report challenges with accessing care and what are the quality outcomes for this population?

EMBRACE PEOPLE AND PERSPECTIVES

Key partnerships and allies will increase the probability of long-term EDI integration. Consider implementing robust guidelines for change management to encourage a safe environment for EDI initiatives and support groups. Creating a structure for accountability may improve sustainability of efforts, including, but not limited to, oversight committees, embedding EDI into the organization's operational goals and objectives, etc. Understand that this is a journey and we will continue learn best practices as we go. Be kind, patient, and bold as we strive to create a better world. We are in this together. **P**

Reference

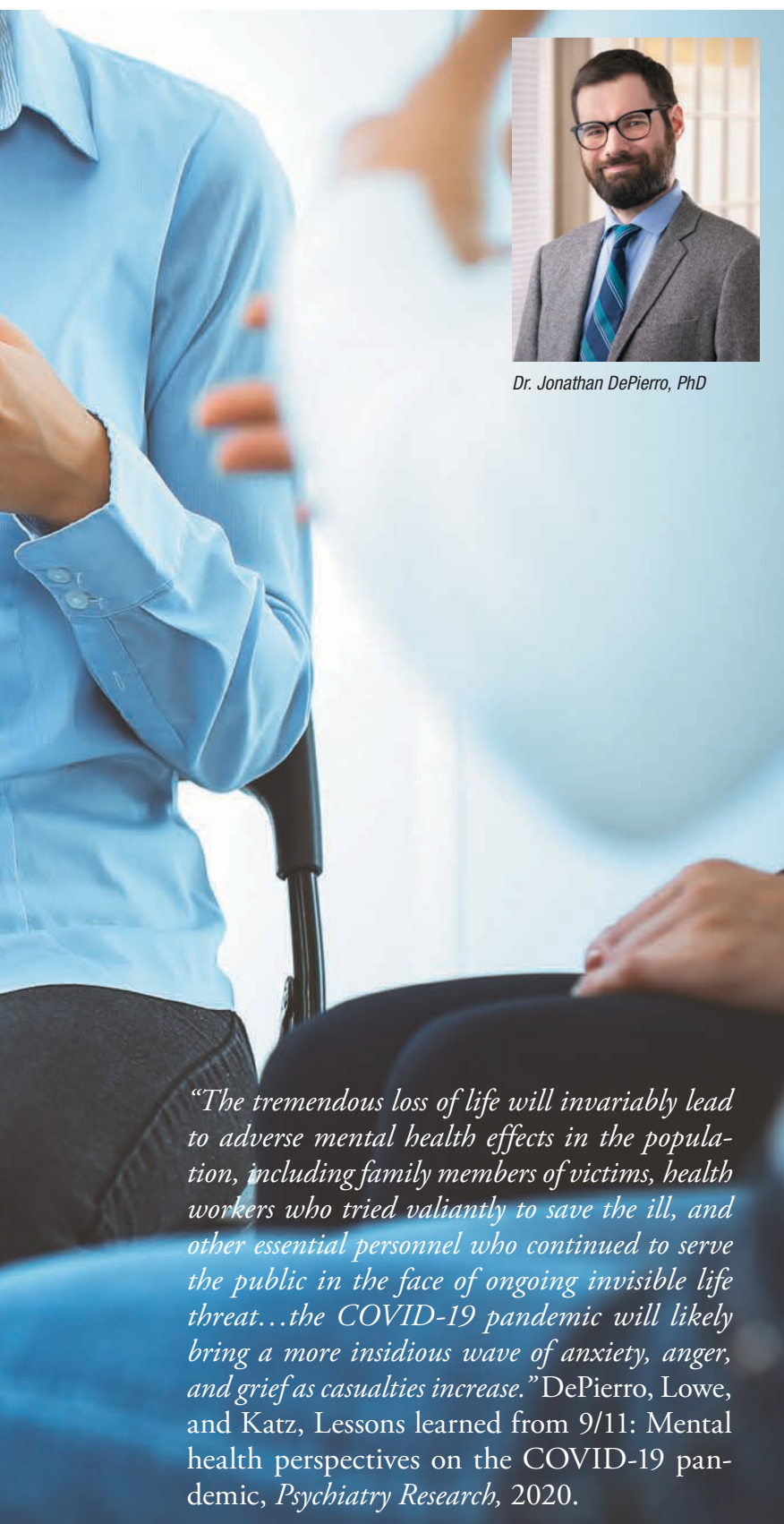
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Shaunté Walton, MS, CIC, is the Health System Director of Clinical Epidemiology & Infection Prevention at UCLA Health, and a Prevention Strategist editorial panel member.

‘Come to care’

An interview with
Dr. Jonathan DePierro on
the importance of leadership
and social support

BY ELIZABETH HABERKORN



Dr. Jonathan DePiero, PhD

*“The tremendous loss of life will invariably lead to adverse mental health effects in the population, including family members of victims, health workers who tried valiantly to save the ill, and other essential personnel who continued to serve the public in the face of ongoing invisible life threat...the COVID-19 pandemic will likely bring a more insidious wave of anxiety, anger, and grief as casualties increase.” DePiero, Lowe, and Katz, Lessons learned from 9/11: Mental health perspectives on the COVID-19 pandemic, *Psychiatry Research*, 2020.*

There is no getting around it: life is hard these days. For healthcare professionals (HCPs) in particular, it’s difficult to see a light at the end of the tunnel and believe it’s a way out rather than an oncoming train. According to experts, one of the 10 factors of resilience is “realistic optimism.” “Don’t dismiss that things are awful,” Jonathan DePiero, PhD, Clinical and Research Director at Mount Sinai’s Center for Stress, Resilience, and Personal Growth, said. “Between long workdays, bigger workloads and people dying, every healthcare professional is taxed in some way right now.” The trick is not to make things grimmer than is warranted. While many are working long hours, and many institutions are dealing with financial strain, a glimmer of hope may cause more anxiety and lead one to wonder when the healing process is finally going to start (or if it ever will). At the Mount Sinai Health System, the healing process may in fact already be underway.

MOUNT SINAI HEALTH SYSTEM

At the Mount Sinai’s Center for Stress, Resilience, and Personal Growth tools and resources on stress management and mental health assessment are provided for more than 40,000 staff members employed in the Mount Sinai Health System. Started in May of 2020 to address the psychosocial impact of COVID-19 on the mental health and lives of its frontline health care providers, the Center hopes to serve as a model for institutions and communities around the world.

Researchers and clinicians at Mount Sinai’s Center specialize in studying resilience and traumatic stress. Many clinicians work with Holocaust survivors and their families, prisoners of war, Viet Nam veterans, and 9/11 responders, to list just a few. They have approached the pandemic with those experiences in mind. “The pandemic and the terrorist attacks in 2001 have a lot of parallels as far as providing and receiving medical and mental health “attention.” But, DePiero said, “the pandemic has been happening for well over a year, and we don’t really know yet what the recovery period will look like.”

DePierro oversees employee-facing resilience training and education, clinical assessment, and interventions. Since July 2020, his team conducted 88 workshops on stress management, either virtually or impromptu on units. “The workshops are pretty popular with leaders and unit staff alike. What we have done is to work with unit leadership to have one or two staff join for a workshop for 30 minutes or so and then they go back to work, there the key is to keep the workshop flexible.” He added, “we also developed an app that is available to our workforce called Wellness Hub, where staff can confidentially assess their wellness and resilience states, receive immediate feedback, and have access to all resources available through the app.”

There is such an overwhelming amount of assistance available, it’s easy for staff to experience something like paralysis as to where to even start in their search for help. One of DePierro’s Mount Sinai colleagues, Dr. Jonathan Ripp, and his team at the Office of Well-being and Resilience, developed an online library where all resources available to staff could be accessed. It’s a good starting point to find a method to receive help, and to determine what kind of help you need. At the Center, a team of social workers are available to take phone calls from 9 am to 9 pm daily. Face-to-face treatment services started in October 2020, and so far, 800 visits have been conducted. The health clinic offers up to 14 free sessions of cognitive behavioral therapy at no out-of-pocket cost to the staff. “The staff member receives cutting edge treatment

Figure 1. Stress Continuum Model.

| READY (Green) | REACTING (Yellow) | INJURED (Orange) | ILL (Red) |
|---|--|---|---|
| <p>DEFINITION</p> <ul style="list-style-type: none"> Optimal functioning Adaptive growth Wellness <p>FEATURES</p> <ul style="list-style-type: none"> At one’s best Well trained and prepared In control Physically, mentally, and spiritually fit Mission focused Motivated Calm and steady Behaving ethically Having fun | <p>DEFINITION</p> <ul style="list-style-type: none"> Mild and transient distress or loss of functioning Always goes away Low risk for illness <p>CAUSES</p> <ul style="list-style-type: none"> Any Stressor <p>FEATURES</p> <ul style="list-style-type: none"> Feeling irritable, anxious, or down Loss of motivation Loss of focus Difficulty sleeping Muscle tension or other physical changes Not having fun | <p>DEFINITION</p> <ul style="list-style-type: none"> More severe and persistent distress or loss of function Leaves a “scar” Higher risk for illness <p>CAUSES</p> <ul style="list-style-type: none"> Life Threat Loss Inner Conflict Wear and Tear <p>FEATURES</p> <ul style="list-style-type: none"> Loss of control Panic, rage, or depressed mood Substance Abuse Not feeling like normal self Excessive guilt, shame, or blame Diminished sense of purpose, meaning, or hope in the future | <p>DEFINITION</p> <ul style="list-style-type: none"> Unhealed stress injury causing life impairment Clinical mental disorder <p>TYPES</p> <ul style="list-style-type: none"> PTSD Depression Anxiety Substance Dependence <p>FEATURES</p> <ul style="list-style-type: none"> Symptoms persist and worsen over time Sever distress, social or occupational impairment |
| Unit Leader Responsibility | Individual, Peer, Family Responsibility | | Caregiver Responsibility |

SOURCE: US NAVY, BUREAU OF MEDICINE AND SURGERY

for anxiety, post-traumatic stress disorder (PTSD), depression, or is taught to challenge negative thoughts and how to see themselves in the world with more flexibility. They learn new ways and methods to manage stress. Some people find medication helpful, as well,” DePierro said.

LEADERSHIP SUPPORT PREDICTS MENTAL HEALTH OUTCOMES

Not every HCP is suffering from PTSD or depression. However, most HCPs are experiencing burnout, which is its own chronic condition with three components: exhaustion, cynicism, and having a low sense of efficacy. “You may find yourself believing that nothing you do is going to

help patients get better, or feeling hopeless and questioning your purpose, or feeling like a failure and thinking you did something wrong, like you should have or could have saved Mr./Ms. X.,” DePierro said. “It’s all related to the idea of moral injury. You may have to make decisions and do things that you feel are up against your moral compass. This is also related to PTSD. We see a lot of PTSD in veterans, but we are now starting to see it in HCPs, as well.”

It’s helpful to keep in mind that burnout, fatigue, depression, all those feelings that can lead to PTSD, generalized anxiety disorder, or other mental health conditions, are not just an individual issue. As DePierro points out, individuals are part of a system, and if many

FOR THOSE WHO WANT OUT

Every institution and profession is seeing staff choosing to leave and it’s creating downstream issues. At the same time, DePierro said, those personal choices need to be respected, but don’t react too quickly. “Speak to friends and colleagues. Don’t make spur of the moment decisions. See if accommodations can be made at work,” DePierro advised.

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- Fostering Resilience in Healthcare Workers Affected By The COVID-19 Pandemic: Presented in collaboration with Mt. Sinai Center for Stress, Resilience, and Personal Growth

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If an issue is affecting your work and personal life, come to care.

people within that system are experiencing distress, it's an indication of a bigger problem. "Burnout is a reflection of structural issues, reflection of workload, unclear communication and priorities, leadership breakdowns, lack of resources, and high expectations or impossible expectations, including your own," DePierro said.

Some signs that your leadership is not supporting you include: a lack of transparency, not forthcoming with information, queries going unanswered, or excessive negativity. "If you feel like you are on an island left to your own devices in an unpredictable situation, then chances are, you are not being supported by leadership," DePierro said.

"The tools and resources for successful mental health need to come from above. Studies have shown that a lack of leadership support does predict mental health outcomes. You can't change combat, but you can change how someone responds to the situation," DePierro said. Thinking creatively and taking pre-emptive actions can help people manage oncoming stressors such as worry about transmitting COVID-19 to older or ill family members, managing childcare responsibilities, and contracting the virus and being out of work or losing jobs because of leave, etc. The list goes on.

REMOVING THE ROADBLOCKS

For some, seeking help for wellness is not so easy. There still exists a stigma for those who seek, and receive, assistance for mental health issues. How do you encourage healthcare workers to get help? DePierro has a few suggestions. "It's helpful to present data to these data-driven professionals. For instance, a study showed that 39% of Mount Sinai frontline workers screened in for probable depression, generalized anxiety, or PTSD since April 2020. The takeaway from that data is: you are not alone. Everyone is affected."

RESILIENCE SUPPORTS

1. Building social support;
2. Facing fears;
3. Coping actively with problems;
4. Engaging in faith and spirituality engaging sources of meaning in life;
5. Realistic optimism—don't wear rose-colored glasses;
6. Modeling yourself after people you admire/respect;
7. Guided by your moral compass
8. Making yourself a priority;
9. Reframing a mistake as a learning opportunity;
10. Holding yourself accountable for your emotional wellbeing.

At the Center, face-to-face contact helps to reinforce that the clinicians are there for the staff, and the hope is that they become trusted faces who are not parachuting in once for a quick check in and then leaving. "Showing our faces on units is a good way to show staff that we are responsive but to also show support, and that we can help to navigate their issues. We are working to establish relationships, to be embedded into the units, and not being unfamiliar and scary but being known to them," DePierro said. It's important that the HCPs are aware that help is present for them, and that getting help is okay, and is easy to do so. And for those who prefer to manage on their own, tools and resources for them are available to do just that.

But there may be a silver lining to the pandemic, after all. "We hope that this overwhelming experience will change some culture around stigma around seeking help for mental health. The pandemic has brought employee wellness and wellbeing to the forefront of leadership, has been made an institutional priority," DePierro said. But leadership must lead by example.

IMPORTANCE OF SOCIAL SUPPORT

The Center is rolling out a broader peer support plan, currently in the early

YOU'RE NOT ALONE

From June–September 2020, Mental Health America (MHA) hosted a survey on mhascreening.org to listen to the experiences of healthcare workers during COVID-19 and to create better resources to help support their mental health as they continue to provide care.

The responses collected from the 1,119 healthcare workers surveyed indicated that they are stressed out and stretched too thin: 93% of health care workers were experiencing stress, 86% reported experiencing anxiety, 77% reported frustration, 76% reported exhaustion and burnout, and 75% said they were overwhelmed.

stages. The hope is to empower HCPs to provide emotional support to colleagues. Psychological first aid incorporates the basics of emotional support.

At its core, psychological first aid is about treating a person in distress as a human being. "When we do disaster response work, we are humans first, then mental health experts, then psychologists, who listen, provide information, validate concerns, provide education about stress the person is experiencing, providing tools to address concern in the moment. All this is very trainable," DePierro said. "Giving support to someone else goes a long way."

Self-care is just as important as being there for others. "Social support is finding someone you can lean on. To me, it's the number one factor related to resilience," DePierro said. "During the Viet Nam War, prisoners developed a 'tapping system,' so even though they couldn't see each other and were confined to isolation, they were aware that someone else was there and experiencing what they were going through, as well," DePierro said. "If other people are taking the journey with you, you are less likely to develop PTSD and more likely to be resilient." P

Elizabeth Haberkorn is associate director, communications, at APIC.



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RETURNING TO THE NEW NORMAL (WHATEVER THAT MAY BE)



The COVID-19 Pandemic and Lessons Learned

BY CARISSA MCGINNIS, WITH VICKI ALLEN, ERIC LEE, JOAN MERRILL, AND PAMELA LONGBINE



Carissa McGinnis

Often, when hospital staff see someone from infection prevention rounding, the initial response is to run and hide. Likely, this is to avoid questions related to isolation precautions or why there is not appropriate use of personal protective equipment (PPE). Staff may be trying to avoid being asked to remove a foley catheter or perhaps, avoid being reminded to perform hand hygiene before and after patient care, or even, quiet possibly, avoid being asked if equipment has been cleaned between patients. Admittedly, this may be coming more from a deep-rooted misperception we had of infection preventionists (IPs) during countless interactions when we were nurses. Regardless of the reason, IPs are really “friends” for all healthcare to embrace. We did not come to this realization until many years later after joining this exceptional branch of healthcare. This is when we discovered how infection prevention is not about telling others what is not being done correctly. Instead, it is a more behind-the-scenes proactive approach, not reactive, and a way of protecting patients and helping them heal from illnesses that attack their bodies with organisms not seen by the naked eye. Infection prevention is also the act of helping the healthcare workers stay safe. Generally, an IP is defined as a person within the healthcare environment whose focus is on preventing infections. Often considered the “expert” in the field of infection prevention, IPs are the ones behind the scenes looking at reports, cultures, and making sure that the healthcare system or organization is up to date and following the latest recommendations from the Centers for Disease Control and Prevention (CDC). This is a global responsibility, with IPs referencing their “gold standard” and often the World Health Organization. From here IPs research, create policies and protocols based on evidence-based practice and current literature, and educate so that everyone better understands the “how and why” of what is being done.

Outside looking in, this all seems pretty cut and dry; and generally it is, with the occasional hiccups of possible exposures, an increase in healthcare-associated infections (HAIs), the emergence of a more resistant new superbug, such as

Carbapenem-resistant Enterobacteriaceae (CRE) or *Neisseria gonorrhoeae*, and the ones that seem to get the attention of staff most of all, bed bugs and lice. Then there is the intermittent threat of emerging viruses like Ebola, that can pose a national

threat if there is not a well thought-out plan of care to tackle it head on.

Our experiences in infection prevention have taught us to be knowledgeable on organisms, diseases, viruses, PPE, how to use resources, how to educate and be

educated, create and improve hospital policies, as well as how to manage the aforementioned issues often seen in the infection prevention and control department; and possibly most importantly, how collaboration with a team of professionals can often thwart off disaster. Then enters COVID-19/SARS-CoV-2. Unable to say this virus hit without warning, it did hit hard and, in a sense, shut down the whole universe reeking a panic as had never been seen before. All things infection prevention went into overdrive and all the things we thought we knew were being tested and tried. Changes were having to be made to accommodate the things that were happening in our healthcare system along with the rest of the nation. As a year in review, we look back and see how things have changed, what has stayed the same, and the lessons we learned.

First lesson. Have a training plan in process for new IPs. To begin with, we had a new IP who had just started 2 weeks prior to having a positive COVID-19 patient in our community and having positive admitted patients in our facility. While this was taking place, our new IP was just in the beginning processes of learning our surveillance system, getting passwords, and being set up to use and enter data on the National Healthcare Safety Network (NHSN) system. That came to a screeching halt and instead this new IP was thrown into learning how to perform multiple daily searches on the CDC site in order to help create standard works and policies for proper PPE for COVID-19 patients and patients under investigation (PUIs). This also included working closely with the operating room (OR) staff and creating a plan for recommended use of N95s, Powered Air Purified Respirators (PAPRs), how to properly clean ORs after use, and who would be allowed in the room during any aerosolized generating procedures (AGP). Interestingly for this new IP, there was also a quick education of air exchanges, how many should be in the ORs and what the recommendations were for switching from positive to negative pressure, and the alternatives that could

be taken. This involved several conference calls (since no in-person meetings were being conducted at the time) and having to educate all staff, including physicians, nurses, techs, managers, and directors. The training for our daily work in infection prevention did not begin again until several weeks later, and this on top of taking part on daily phone calls, emails, and face timing. Welcome to infection prevention! The lesson learned from this is making sure that our department is well prepared for bringing someone on board. The idea is to create a handbook, and update it often, that has our department's daily work and a description of how to perform these tasks including systems to use and information for documentation.

Second lesson. Make sure there is enough PPE for the facility and learn to stretch what resources are available to accommodate the needs of the staff. As we started to see an increase in positive COVID-19 results, we began to take precautions based on the recommendations of the CDC. It seemed that only a week prior to having a positive COVID-19 result we were telling staff not to wear surgical mask in the halls of the hospital and to discard them as they exited patient rooms. Then we were having to back track and tell staff not to enter the units without a surgical mask, and soon after this, an N95. As our hospital began filling up with positive COVID-19 patients and PUIs, we found ourselves in the throes of the dilemma of shortages for surgical masks and N95s. Our organization quickly went from having months' worth of N95 respirators to a supply for just days. After reaching out to supply chains and local coalitions, along with much discussion, it was decided to practice limited reuse of our N95 respirators. After limited research, our organization adapted a process for using ultraviolet radiation for decontamination and reuse of N95 respirators. After working closely with our facility services department, we devised a plan, created standard work procedures, and provided education to staff about the decontamination process

for our respirators. We learned how, in a relatively short period of time, a healthcare organization can improvise using very limited studies and rapidly deploy a process to safely address the limited reuse of much needed supplies.

Third lesson. No matter the situation, surveillance must go on. When COVID-19 reared its ugly head, the daily work life for our infection prevention department changed, and all hands were on deck. We went from sitting in front of a computer screen to performing nasopharyngeal swabs in drive-through sequence to check patients for COVID-19. In all of this, some of our surveillance did fall behind, and we did have a bump-up in our HAIs. However, because of some of the policies and protocols that have been previously implemented, we were able to keep HAIs for our central lines and foley catheters as well as *Clostridioides difficile* (*C. diff*) to a minimum. Our lesson learned: daily surveillance is important and must continue, no matter the situation. We learned that having nursing protocols in place for removal of foley catheters as well as orders for collecting stool for *C. diff* is an important part of the daily process to reduce HAIs. We found it is imperative to make sure that the education for such protocols is taught to physicians and nurses alike on a routine basis.

Many changes have occurred for IPs... some good and some not so good, but almost all of them have centered around the importance of good infection prevention practices and controls. We have learned that everyone can wear a mask and wash their hands and that we can protect each other by staying home when we are ill. We have learned that we need and can depend on one another in our own communities and that we continue to be hopeful as we transition toward a "new normal."—whatever that may be. **P**

Carissa McGinnis is a certified infection preventionist for CaroMont Regional Medical Center in Gastonia, NC. She has been in the IP roll for the last 4.5 years and currently is part of the APIC Communications Committee.

Returning to the new normal: Lessons learned during a COVID-19 Reality Journey

BY PATRICIA GRANT

Oxymoron(s) are useful

The moment of an infectious event mostly goes unnoticed. Things look clean and normal to healthcare providers and patients alike—this was and remains our return to normal. I’ve heard people say variations of “you just don’t know when something is the last time,” yet I vividly remember the last moment of old normalcy at work. It was 01/24/20 in a hotel room in San Antonio, Texas (USA), around 5:30 pm after a day of APIC volunteer work. It was time to review e-mails and discover what happened at work for that day, when I came across the CDC Press Release¹ outlining the “Second Travel-related Case of 2019 Novel Coronavirus Detected in United States,” and I debated if staff should be formally notified. After all, this was only the second case and not domestic transmission: the blast notification was sent after the “Yes” won my internal debate, and this rest is, well, history, for each of us within our own reality.

Returning to the new normal happened with little fan fair. You’d think being an Infection Preventionist (IP) since January 1990 would have prepared me for the fluid uncertainties of the COVID-19 pandemic. Being an IP, at the core, is about practicing the skills to seek the origin of a problem (root cause), fix it (correction), and help organize system(s) so it is harder for *that* to happen again (prevention). We are akin to the police officer that trains in the use of deadly force and hopes those skills are never needed. The difference is our quest centers on preventing infection: literally, an often invisible menace. A single germ cannot be seen with the naked eye, only the transport media, or aftermath of an active infection is recognized when the redness, heat, drainage, fever, or confusion take hold as the body tries to defend itself.

Lessons learned during COVID-19

This article does not pretend to summarize the remarkable formal evidence-based work published by those that have dedicated their lives to epidemiology and/or public health. The basic lessons I learned adapting to the impact of COVID-19, also known as “crib notes” are not complex once drilled down to their essence. It is our job to share a complicated knowledge base with different types and levels of communication. When things got overwhelming, I grounded myself

in the concepts that drive an Infection Prevention and Control (IPC) program, so that non-IP’s could easily relate (see Figure 1). After that, it was off to the races with an ever-changing plan to stop COVID-19 transmission.

In retrospect the decision to send that all-staff e-mail seemed inconsequential at the time. The communication was treated with a “just in case” philosophy. Without actively realizing the ultimate purpose of this “just in case” approach, I had engaged the training of APIC, the teaching of mentors that shared their knowledge and time, as supported by prior IP networking. Unknown in that moment, the groundwork for trust was sought amid those that work the frontlines of our healthcare facility each day: preparing for the unknown with a “just in case” communication. It worked as best as can be expected in the midst of a global pandemic, even within the walls of a 32-bed orthopedic specialty hospital. *Lesson #1 is seek a mentor, then be a mentor, and volunteer your time within APIC.* You will *always* learn through these processes, even if pandemic-level skills are not needed again in your lifetime.

To save you from time losses generated by repetition, *lesson #2 is to document your IPC consultation decisions² outside of formal committee structure.* The COVID-19 pandemic IPC world became relentless with questions, which

almost paralleled the rapidity of CDC interim guidance updates as the science unfolded. Quickly I learned to save responses (answers) in an aggregate database (simple e-mail file trees) by placing the date at the head of the subject line for quick retrieval and forwarding. Why did this earn the *Lesson #2* spot? Because 84% (5,141/6,090) of U.S. hospitals are designated as “community” and 67% (3,453/5,141) of those are system-affiliated, and capable of quickly sharing knowledge and protocol resources.³ Stated another way, 33% of U.S. community hospitals may not have had robust IP support infrastructure, making working “smarter not harder” a critical goal. This pandemic inadvertently helped me secure a time-saving system, regardless of the problem at hand. Any IPC situation that remotely hints at being convoluted will get a separate tracking system by date.

Lesson #3 saved countless hours of avoidable disputes and repetition of shifting COVID-19 facts. It was obvious by mid-March 2020 that the traditional policy approach for COVID-19 was not a good safety option. A policy would become obsolete in several sections without much warning, multiple times, over the course of sometimes days. The SARS-CoV-2 virus, and variants, remain unpredictable and that means updates based on the emerging science of the organism. Working in an ISO 9001:2015-certified healthcare

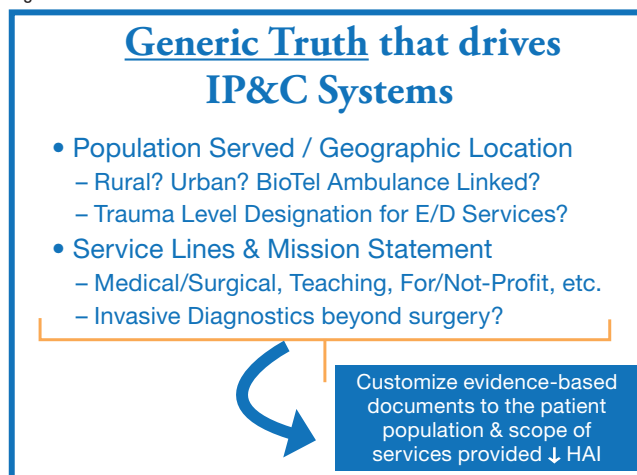
facility,^{4,5} I've been trained in the “one-right document” approach to quality management systems (documented information). Stated simply, there can be only one correct document (source) for correct information (policy, procedure, form, protocol). Since the COVID-19 pandemic was (is) unpredictable, the IP reviewed (sanctioned) what **could be used** for the healthcare facility COVID-19 decisions. These controlled documents are accessible for any staff member that has a secure password to access a computer within the facility.

The IP-approved content (*Lesson #3*) remains organized for quick drill-down of a vast amount of *current* information for staff and IP use: (a) Public (can print for general public use and patient teaching); (b) Staff (protocols, procedures, formal documents, archived blast e-mails); and, (c) Publications (WHO, CDC, Texas Department of State Health Services, APIC, SHEA, IDSA, etc.). As the swiftness of CDC updates escalated, several of these resources became actual links to a reputable website topic; thus, always current without the IP having to update the document. Having this fluid and ever-ready “IP-approved” content was a gift to avoid unnecessary engine searches when a well-meaning healthcare professional shared “how to sterilize N95s in the oven.”

Asking for help while saying “I might not be the best person for this task” is *lesson #4*. This was applied when queried to “set-up the screening/testing program(s)” or “report the negative surveillance COVID-19 tests.” Technically, I think of this as letting go with facilitation, which can be harder, but with good outcomes when you stay peripherally involved. Professionally, yet succinctly, I stated that “I don't have an implementation staff. The IP's area of expertise is being the content expert responsible for culling through the myriad of scientific publications and getting the right information to the managers,” with staff that can implement the physical necessities. Most importantly, I was *able* to be the content expert because I made myself engage in *Quadrant Two* of Covey's Time Management Matrix⁶ (Important/Not Urgent) to plan for the return to the new normal (routine surveillance, policy review, survey readiness) while making progress on COVID-19. The aim here was to not let IPC activities stagnate elsewhere, creating a potential conundrum from abandonment of mainstay obligations.

Fairly quickly I was grateful for *lesson #5* that was passed on by various mentors: get on as many “push Listservs as you can” and skim the content daily. Listservs from the CDC, state and local health department, FDA MedWatch, APIC Public Policy, just to name a few, became my lifeline. Without my “morning coffee” of 2 to 3 hours reviewing the emerging COVID-19 content, it is doubtful I could have managed as well. The collective and vetted brain trust, which often included information on webinars, was priceless. When pressed with “how do you know this is the right thing?” my answer was consistent: we date/time the CDC interim guidance, use the state interpretative documents, and these become our gold standards. Nobody *really* knew “this is the right thing” for certain, so *lesson #5* made it much easier to identify the correctness for that particular date and time.

Figure 1



The COVID-19 pandemic, and the information shared by “staff blast e-mails” kept the IP presence in the forefront, so the COVID-19 prevention mission was visible, even when the IP is physically not present. The final crib note is “*Lesson #6: communicate with ‘WIIFM’ (what’s in it for me) as your driving principle.*” Along with the requisite public health statistics, healthcare-associated and employee health mainstays, I started to share non-traditional information. Blast e-mails regarding COVID-19 and pets, schools, businesses, sports, daycare, gyms, doing personal essential errands, etc., became an expected stronghold of our culture. Staff forwarded these blast e-mails to family and friends. A wonderful byproduct occurred: our staff became *the* source of *correct* COVID-19 information within *their* circle of contacts outside their employment. Unexpected “thanks” started to happen, which was a welcome gift in the midst of self-doubt. This made coming to work less stressful. Why? Maybe it was because staff was armed with IP-sanctioned information to share with those in their lives. At the end of the day, it might have given them some control during one of the darkest pandemics since 1918, when control was no longer a commodity, and we all were trying to find the new normal. **PS**

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Patti Grant, RN, BSN, MS, CIC, FAPIC, is infection preventionist/ISO lead auditor at Methodist Hospital for Surgery. She was APIC's president in 2013.

New normal for a higher learning campus IP

BY BRIGETTE LAO

Being in charge of infection control in higher education pre-COVID-19 meant having a robust TB testing and immunization program, managing STIs, and being a resource to help prevent the spread of diseases in dormitories. Campuses are hubs of student activities existing in a unique ecosystem where they learn socialization skills and attain academic goals. The COVID-19 pandemic has made university campus life so different than what it was before and created a dramatic transformation in this ecosystem. We currently anticipate return to in-person classes, sports competitions, and residence halls teeming with students. While the rates of infection are slowly going down and more people are getting vaccinated, we continue to keep our guard up and take care of our campus population. The objective is to keep everyone safe to attain their academic goals, therefore, we cannot get complacent or lenient with the knowledge and lessons that we have learned.

What will campuses look like in the coming months?

Hand hygiene, masking, respiratory etiquette, physical distancing. These protective practices will continue. Signs for physical distancing on the walls and the floors all over campuses and offices will stay up. Hand sanitation stations will remain a common sight because access helps hand hygiene practice. People walking around in masks will remain a common sight and an expectation.

COVID-19 vaccinations. Pre-COVID-19, higher education students were required to complete TB testing and screening together with completed doses of mumps, measles, rubella, varicella, Tdap, meningococcal, and Hepatitis B for health sciences. A growing number of universities and schools are announcing mandatory COVID-19 vaccinations before the first day of classes or campus arrival. For campus IPs, the pre-COVID requirements pose as a challenge when mixed with COVID-19 vaccinations. Per CDC guidelines, TB testing, whether IGRA or TST, can only be done 28 days after the COVID-19 vaccination. Balancing and prioritization of these requirements will be a decision point for IPs. Many campuses have opted to make COVID-19 vaccination as the priority. This means a potential delay in TB testing and other vaccinations.

Health check points, waiting areas, classrooms. More than a year ago, clinics came up with a way to streamline entry to facilities for staff and patients.

Temperature checking and asking questions about COVID-19 symptoms became a norm. These practices will stay. For IPs, this means working closer with facilities management and custodial staff to maintain engineering controls. It also means coordinating with purchasing units to secure more hand hygiene supplies, accurate thermometers, and PPE.

COVID-19 surveillance testing. For IPs, it is vital to review data on how many people who eventually tested positive showed up in asymptomatic testing centers. A periodic review of infection control processes in these centers is also worthy of the IPs attention. Surveillance testing for COVID-19 will continue for staff students and faculty. This is also called asymptomatic testing because the students are not reporting any signs and symptoms associated with COVID-19. Various groups use different ways to test students. It can be in the form of campus testing centers or vending machines to secure the test kits. Student athletes are expected to test more frequently than the regular students. NCAA provides updated guidelines. Based on regulations, referees need to have COVID-19 antigen testing before being allowed for games.

Contact tracing and covid clearances. When the pandemic started, not all students left the campuses. There are thousands who opted to stay. The same holds true for essential staff who needed to maintain operations. This necessitated the need for schools to enter into agreements with the county or city health

departments to be given the authority to perform contact tracing. In the new normal, this arrangement will continue and become very important with the plans to start populating dormitories, holding face-to-face classes, resumption of research, and other campus events.

Most student health centers and occupational health centers initially struggled on the workflow and implementation of clearances for students and staff from isolation and quarantine requirements. By this time, the workflows are more robust and clearances are issued in a timely manner. The new normal will include more frequent quarantines among athletes, sororities, fraternities, and other organizations who have increased frequency of contact with one another.

COVID-19 drive throughs testing centers. IPs made valuable contributions in setting up drive through testing centers. All these centers will continue.

Daily symptom checks for students living, working, and studying. The daily symptom checks will keep everyone safe. Students and staff will undoubtedly experience “answer fatigue” since the reminders to answer symptom checks arrive daily. However, these reminders in the form of e-mails or messages through Apps will be a new normal.

Students come to universities for a meaningful campus experience. But when they come back, many things will have changed. It is the same for IPs. The role of the IP remains the same but the nuances of the practice have changed. **P**



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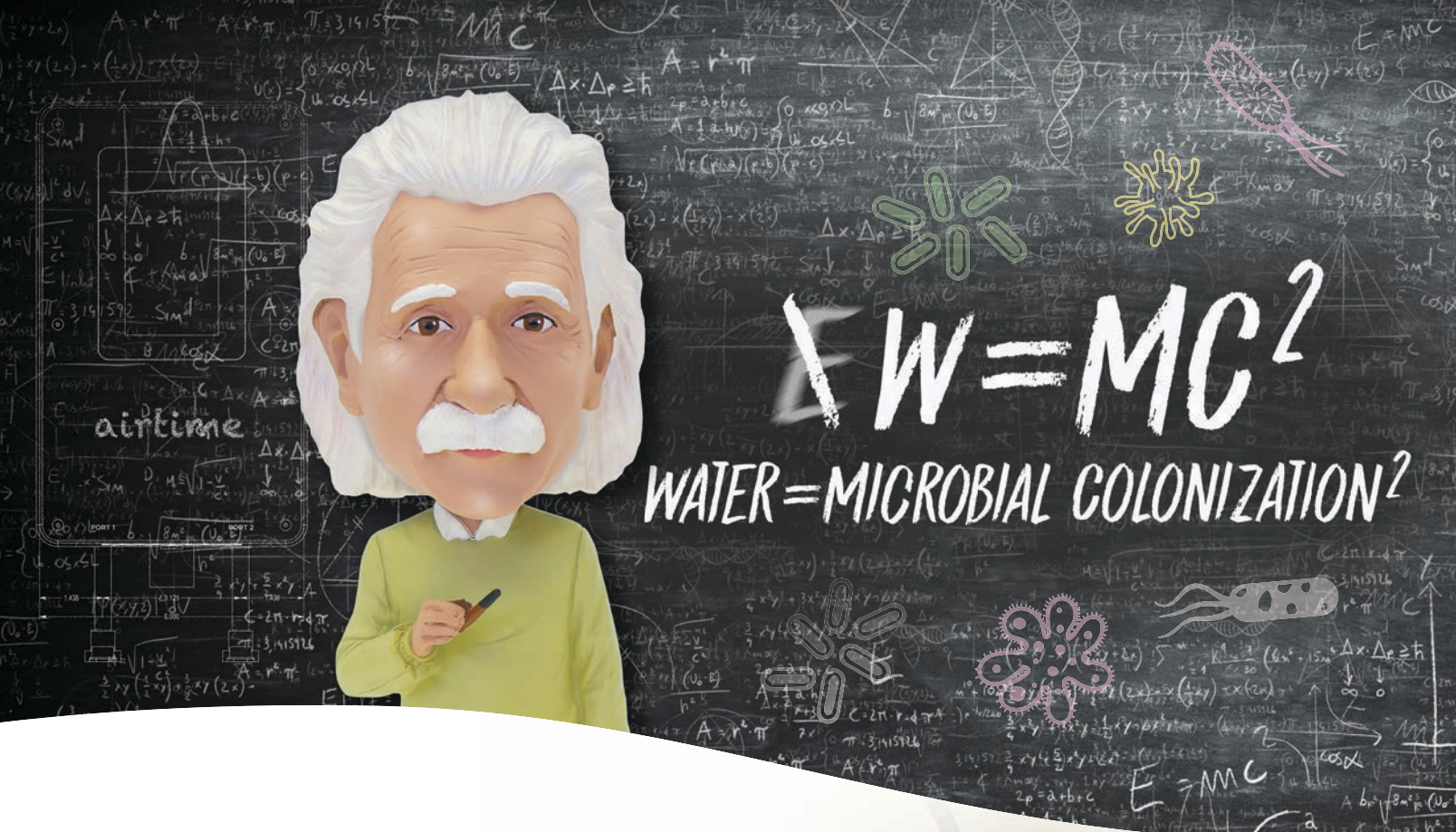
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