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www.apic.org
Recently, we had the great pleasure of speaking with Kay Wenzel Owens, who was one of APIC’s founders and who, along with Patricia Lynch, would go on to serve as APIC’s first President-Elect and President, respectively. As we enter the halfway point of our 50th anniversary year, we thought that we would go back in time to honor our past and, at the same time, build a bridge to our future.

For those of you who haven’t had the pleasure of meeting Kay, she was an early pioneer in the field of infection prevention and published a seminal article in 1970 on the role of what was then termed the “infection control nurse” (read selections from our interview with Kay on pages 48–49). We had a chance to visit with her to learn more about her background and the early years of APIC. Kay, who is now in her 80s, recollected the dedication of our early founders and their commitment to supporting one another in the effort of preventing infections. Kay noted the dedication to build a network so that those focused on preventing infections could share best practices and ideas for improvement…sound familiar?

A CDC servant leader played a pivotal role in APIC’s beginning. Kay noted that it was CDC staff member Claire Coppage, who believed passionately that an organization that brought together those who were committed to preventing infections in healthcare would be formed. Claire outlined the beginnings of APIC in our first newsletter (March 1973) titled “What is Past is Prologue”:


The question naturally arises: how did APIC get its start? This newsletter recounts the founding:

“In 1969, several nurses attending the CDC course Surveillance, Prevention, and Control of Hospital-Associated Infections came to me as Course Director and voiced the need for a national organization of those working in infection control programs. The spokesperson for the group was Lucille Arkin of the University of Kentucky, and she asked me to name a committee to investigate the possibility of organizing such a group.”

The document goes on to say there was a need for an organization that could enhance communication between infection control programs and provide information on current infection control recommendations. The newsletter also notes that the intention was for the organization to be multi-disciplinary. It defined the purpose of APIC at the time to “unite healthcare workers of all disciplines who share the common goal of improving patient care through infection control activities” and set the primary goals to “enhance communication, develop educational programs, and standardized techniques and programs of infection control.”

These fundamental ideals for connection, communication, sharing of ideas, best practices, and education permeate the very fabric of our organization. There’s one particular quote from the first newsletter that talked about how the founding committee “[worked] three days and nights, accomplished miracles, and still [were] friends.”

While APIC has expanded in so many ways since our humble beginnings, these core characteristics are still at the heart of the organization today and will continue to guide us into the future.

It is important to know why and how we became an organization. As the future of APIC and our collective efforts evolve, we must remember those who first boldly dared to dream and worked so tirelessly to make that dream a reality. This is a call to our 15,000 members. You are the leaders that will shape the next 50 years. As our founders first lit the torch, it’s now our time to carry it forward.

Devin Jopp, EdD, MS
APIC CEO
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LEADING WITH OUTCOMES
The Certification Board of Infection Control (CBIC®) congratulates APIC on its 50th anniversary. Reading APIC’s history and the dedication and vision of these early trailblazers is an inspiration for us all. The early APIC leaders identified the importance to have all infection preventionists (IPs) demonstrate a common body of knowledge and skills considered to be essential to their practice, and to this end APIC created the APIC Certification Association and its first board committee. Forty years ago (1982), our name officially changed to the Certification Board of Infection Control and Epidemiology (CBIC).

CBIC celebrates the many milestones that have been reached over the years, but this is not the end of the journey! We continue to strive for professional recognition with certification and promote this globally and in different sectors.

IPs in long-term care homes play a crucial role in keeping vulnerable communities safe. Now, for the first time, individuals with responsibility for infection prevention and control (IPC) programs in long-term care settings can obtain certification that is more tailored to their role and will signify their commitment to providing safe care. Our goal in developing the new certification is to ensure that IPs working in this sector can demonstrate that they are well-equipped to build strong IPC programs to protect residents and staff.

CBIC will begin accepting applications for the new certification in July 2022 with an initial testing period opening in September 2022. For more information visit the CBIC website at https://www.cbic.org/.

We hope that you will have an opportunity to attend the June 2022 APIC education conference in Indianapolis and we hope you stop by the CBIC booth. Learn more about our different types of certification and your options for recertification. Tell us about the milestones you have achieved over the past year and how CBIC and certification can be part of your journey.

About CBIC

The Certification Board of Infection Control & Epidemiology, Inc. (CBIC) is a voluntary, autonomous, multidisciplinary board that provides direction for and administers the certification process for professionals in infection control and applied epidemiology. CBIC is independent and separate from any other infection control-related organization or association, but does collaborate with three partner organizations (APIC, IPAC Canada, and IFIC) to help promote the importance of being certified in infection prevention and control (CIC).

Sandra Callery
2022 CBIC President
Reduce Your Risk of Costly SSIs

Surgical site infections, often caused by contaminants in OR air, cost U.S. hospitals between $3.5 and $10 Billion annually and roughly $34,000 per case.

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Congratulations to the 2022 APIC award recipients!

**Carole DeMille Achievement Award**

Janet Haas, PhD, RN, CIC, FSHEA, FAPIC

Janet P. Haas, PhD, RN, CIC, FSHEA, FAPIC, is the recipient of the 2022 Carole DeMille Achievement Award. The award is given to an individual who has advanced the practice and profession of infection prevention and control through proactive activities, strategies, and leadership.

Haas has served as an infection preventionist and leader in the field for more than 20 years. In that time, she has built a career defined by “distinction, credibility, and prestige.” Haas has dedicated her career to advancing the science and practice of infection prevention and control, and has served APIC in many leadership roles. She has served on the APIC Research Committee, as an associate editor for the *American Journal of Infection Control* (AJIC) since 2008 and also as a section editor of “Methodology Minute,” for several years. In 2012, she was the inaugural chair of the APIC Professional Development Committee, which, under her leadership, started work on the development of APIC’s first IP Competency Model and the Fellow of APIC designation. She was elected to the APIC Board of Directors in 2014 and served as APIC’s 45th president in 2018.

Haas fosters progressive and innovative approaches to infection prevention in her staff and inspires it in her colleagues. As an early advocate for diversity, she believed that a mix of age, racial and ethnic backgrounds, and educational preparation would best serve the profession and strengthen its future. During her year as APIC President, she focused on attracting and developing the next generation of IPs and on the 2018 Consensus Conference. The conference helped to identify APIC’s next strategic priorities with particular attention to an inclusive approach.

Haas has authored and co-authored more than 50 publications on issues relevant to infection prevention, including outbreaks of multidrug-resistant organisms (MDROs), antimicrobial resistance, surgical site infections (SSI), surveillance, construction and healthcare design, isolation precautions, statistics, informatics, and hand hygiene.

**Healthcare Administrator Award**

Mary Jo (MJ) Morrison, MT(ASCP), MBA

Mary Jo (MJ) Morrison, MT(ASCP), MBA, is the recipient of the 2022 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).

As the Vice President of Quality and Chief Quality Officer, Morrison is a true IPC champion at Regions Hospital in St. Paul, Minnesota. A true “boots on the ground” leader, Morrison motivates her frontline staff and providers to function as a high-reliability organization, having coined the term “If you see something say something, if you say something do something.”

Morrison’s leadership and expertise have resulted in effective improvements for staff and organization alike. She introduced a new infrastructure that improved quality and patient safety by ensuring teams include operational leaders, frontline staff, physician champions, improvement consultants, data analysts, IPs, and executive sponsors. Under Morrison’s leadership, a dashboard report built within the electronic health record was created for use by nurses and physicians during partner rounding. This dashboard has been instrumental in helping to sustain improvements in decreasing HAIs. Morrison utilizes the data to inform staff where efforts and resources are best utilized to improve performance opportunities.

Morrison is innovative in her approach and communications, as proven by her “high reliability minute” updates, in which Board members are educated on progress and developments of the IPC department, as well as holding “Board rounding” sessions, where Board members will round in a unit or department and get feedback on what is and what is not working, and inquire about staff ideas for improvements, such as with *C. diff* infection prevention.

As a result of Morrison’s engagement, Regions Hospital has experienced several decreases in infections: a 62% decrease in *C. diff* infections from 2016 to 2019; and a 61% decrease in CAUTI from 2016 to 2019, which has been sustained during the pandemic surges.
President’s Distinguished Service Award, in honor of Pat Lynch
Sharon Williamson, MBA, MT(ASCP)SM, CIC, FAPIC

Sharon Williamson, MBA, MT(ASCP)SM, CIC, FAPIC, is the recipient of the 2022 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.

Williamson’s healthcare career spans more than 30 years. She currently serves as the Senior Director of Infection Prevention for Texas Health Resources (THR), a large healthcare system serving North Texas. Williamson is recognized as an expert in the field of IPC not only within the THR healthcare system but across the DFW metroplex.

With her leadership and expertise, THR System Infection Prevention Program has developed into a highly reliable, hardwired program that is a leading system in the DFW area. Williamson was instrumental in the early planning stages of the state’s HAI reporting in 2009 and then championed this practice through teaching NHSN State-wide Training for Texas in 2010-2011. In 2013, Williamson became the first THR system IP director. Prior to this new position there were no system approaches or resources for the infection preventionist. Williamson created several sub-workgroups to manage different aspects of IPC including Hand Hygiene, Reducing Healthcare-Associated Infections, Regulatory Readiness and Compliance, Emerging Infectious Disease Preparedness, Reducing Disease Transmission, and Elevating the Role of the IP.

Williamson’s passion for infection prevention extends beyond her healthcare system and local community. Williamson served as Secretary for the DFW APIC Chapter in 2015. She also served on the national APIC Board of Directors from 2012-2013, APIC Education Committee in 2016, and was APIC Treasurer from 2017-2018.

Williamson is a strong advocate for IPC mentorship and education and sees the opportunity as an APIC faculty member to mentor new and seasoned IPs. She has worked diligently to ensure that the future of IPC is strong and capable and has left an inspiring mark on the next generation.

Distinguished Scientist Award
Peter J. Hotez, MD, PhD.

Peter J. Hotez, MD, PhD, is the recipient of the 2022 Distinguished Scientist Award. The award is given to an individual who has made outstanding and sustained contributions to the profession through service within APIC.

As both vaccine scientist and autism parent, Hotez has led national efforts to defend vaccines and to serve as an ardent champion of vaccines going up against a growing national antivaccine threat. An internationally recognized physician/scientist in neglected tropical diseases and vaccine development, he is Dean of the National School of Tropical Medicine and Professor of Pediatrics and Molecular Virology and Microbiology at Baylor College of Medicine and Co-Director of the Texas Children’s Hospital Center for Vaccine Development. He is an elected member of the National Academy of Medicine (Public Health Section) and the American Academy of Arts and Sciences (Public Policy Section) and is founding Editor in Chief of PLoS Neglected Tropical Diseases. Hotez serves as co-head of the Lancet Commission for Vaccine Hesitancy.

In 2014-2016, Hotez served in the Obama Administration as U.S. Envoy, focusing on vaccine diplomacy initiatives between the U.S. government and countries in the Middle East and North Africa. In 2018, he was appointed by the U.S. State Department to serve on the Board of Governors for the U.S. Israel Binational Science Foundation and is frequently called upon to testify before U.S. Congress. He has served on infectious disease task forces for two consecutive Texas governors. In 2020, he served as a thought leader and spokesperson for our nation’s response to the COVID-19 pandemic.

In 2017 he was named by FORTUNE Magazine as one of the 34 most influential people in healthcare, while in 2018 he received the Sustained Leadership Award from Research! America. In 2019, he received the Ronald McDonald House Charities Award for Medical Excellence.
2022 APIC award recipients continued

Emerging Leader in IP Award
Kristin Beideman, RN, MPH, CIC

Kristen Beideman, RN, MPH, CIC, is the recipient of the 2022 Emerging Leader in Infection Prevention Award. Throughout the COVID-19 pandemic, Beideman has showcased her skill and leadership in infection prevention.

As Director of Infection Prevention and Emergency Preparedness at UR Thompson Health, Canandaigua, New York, Beideman developed a comprehensive COVID Plan for the entire organization. She serves as a command center leader and has incorporated the emergency management and OSHA plan into policies, procedures, and guidelines while leading prevention and mitigation efforts.

Beideman was the lead for the implementation of the e-record infection prevention module for her hospital and mentors IPs from smaller hospitals in the system. She has worked on various modules and processes to maximize efficiency, incorporate distance learning principles, and leveraged the EHR to develop a robust electronic surveillance plan for the many ambulatory, primary care practices, and the long-term care facility associated with her hospital.

Beideman has developed a comprehensive program for Back to the Basics, engaging the frontline staff in IPC. She is in the process of creating and implementing SSI bundles to standardize practices across surgeries within her hospital system.

Beideman has been recognized by her administration as a leader and influencer. In 2021, she was nominated by her leadership and was awarded the COVID Heroes Award by the Rochester Business Journal. She is also a fire fighter and uses her IPC expertise in her role in Emergency Management and Environmental Safety. As a member of Team Rubicon Disaster relief, she assisted with hurricane relief efforts this year in Louisiana.

Beideman represents the future of IPC and the power of emerging leaders to significantly impact on our community, our patients, and our colleagues.

APIC-SHEA Award for Lifetime Contribution to the Field of Infection Prevention and Epidemiology
Andrew Streifel, MPH, REHS

Andrew Streifel, MPH, REHS, is the recipient of the 2022 APIC-SHEA Award for Lifetime Contribution to the Field of Infection Prevention and Epidemiology for his contributions to the field throughout his career.

Streifel is one of the most highly regarded environmental specialists in the country, if not the world. Throughout his career he has been called upon by his peers and colleagues when vulnerable patients were sickened or at risk from environmental challenges in the healthcare setting including water, air, and conditions from natural disasters. He has traveled the globe to make sure the world is a cleaner, safer place for patients and healthcare workers.

Collaborating with leading healthcare manufacturers, Streifel provided real-life field assessments in the development of tools designed to better measure and manage air and water quality in healthcare facilities. His educational outreach included University of Minnesota public health students, infection preventionists, engineers, contractors, as well as carpenters and other professionals through classes, training seminars, and many individual consultation sessions. Throughout his career, Streifel has inspired several microbiologists to dedicate their futures to infection prevention and control. His work remains relevant today through his collaboration and contributions to the development of professional guidelines that improve patient safety in the healthcare environment, including ASHE, ASRA (FGI Guidelines), CDC, and APIC.
Heroes of infection prevention

Leadership: Kelley Knapek, MPH, BSN, RN, CIC, CWON
Good Samaritan Medical Center, Lafayette, CO

Leadership: Jeffrey Miller, MD, MPH, CIC
Pennsylvania Department of Health, Harrisburg, PA

Leadership: Jodie Leonard, BS, RN, CIC
Gunnison Valley Health Hospital, Gunnison, CO

Quality Improvement: Patrick Gordon, DNP, RN, CIC
Beth Israel Deaconess Medical Center, Boston, MA

Chapter excellence

Puget Sound (large)
Indiana (large)
North Carolina (large)
Greater Atlanta (large)
Greater Baltimore (medium)
Utah (small)

Chapter leaders

Tiffany Horsley-Kesinger, BSN RN, CIC,
Greater Kansas City, KS & MO Chapter
Janina-Marie Tatar, MBA, MT, CIC,
Three Rivers/Pittsburgh, PA Chapter
Patty Montgomery, RN, MPH, CIC, FAPIC,
Puget Sound, WA Chapter
Erica Jones, BSN, RN, CIC,
Greater Baltimore, MD Chapter
Katelynn Harms, MPH, CIC,
Badger, WI Chapter

Scholarships

APIC Graduate Student Award:
Janina-Marie Tatar, MBA, MT, CIC (ASCP)

Research awards

Blue Ribbon Abstract Awards
Erin Hitchingham, MPH, CPH,
Tennessee Department of Health
Louise Lie, MPH Louise Lie, MPH,
Loyola university medical center
Keith Olenslager, MPH, UCI Health
Sarah Stream, MPH, CDA, RDA, EFDA, FADAA,
Nebraska Medicine

New Investigator Abstract Award
Haley R. Gurney, MPH,
Michigan Medicine

William A. Rutala Abstract Award
Megan Wallace, MPH,
University of Pittsburgh

Best International Abstract Award
Rozina Roshanali, MScN, CIC,
The Aga Khan University Hospital

Implementation Science Abstract Award
LaShawn Scott, DNP, RN, CCRN-K, CIC,
University of Louisville Hospital

APIC/AJIC Award for Publication Excellence
Jeanine P. Guidry, PhD,
Virginia Commonwealth University

IPC Operations: Erin Minnerath, MSPH, CIC; Tiffany Martens, RN; and Angie Silva MT (ASCP), CIC
St. Mary's Medical Center, Grand Junction, CO

IPC Operations: Elizabeth Richardson, MSN, MPH, RN, CIC
Beebe Healthcare, Lewes, DE

BD, a long-term strategic partner, is pleased to support the Heroes Program
In Memorium — Deanie Lancaster

APIC has learned of the sudden passing of Deanie (Ava) Lancaster, RN, BSN, CIC. Deanie served as APIC President in 1996. She was known as a kind and inclusive leader; someone full of joy, wisdom, and concern for others; and determined to always do the right thing. Appreciating a good joke, Deanie could make others double over with laughter, and could deliver bad news to someone while making them feel good at the same time. She will be missed by all who knew her.

“We are allies working toward a common goal, one that unites us as patient advocates for quality and safe care. I will always have a soft spot in my heart for APIC because of the wonderful opportunities it has afforded me to see beyond my own small world.”

– Deanie Lancaster

Show Daily

Attending APIC 2022 Annual Meeting, in person or virtually? Make sure to catch Show Daily, APIC’s daily newspaper at the annual meeting. Stay current on meeting happenings, features, and highlights. Four issues will be emailed to all attendees, distributed in print in Indianapolis, and made available on social media, Sunday through Wednesday with a final “Highlights” issue available on Friday. Look for mentions and pictures of peers, friends, and possibly yourself!

New APIC Implementation Guide for Dialysis Settings

APIC is pleased to announce publication of its newest implementation guide, Infection Prevention and Control in Dialysis Settings. This updates the 2010 guide and includes more information on peritoneal and home dialysis as well as guidance for special populations and emergency preparedness. Download your free copy today at https://t.e2ma.net/click/8lr04f/4asurzb/4urro6.

International IP Day Wrap Up

On April 1, APIC celebrated the third annual International IP Day. #InternationalIPDay was used to connect and celebrate IPs across the world. APIC also shared fun IP-related graphics, and APIC staff also thanked our hardworking IPs with a thank-you video you can watch at https://bit.ly/IPDayThankYou2022. Downloadable graphics are appropriately sized for Facebook, Twitter and Instagram.

Infection Prevention and Control in Dialysis Settings

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⁴Data on file.
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Pandemic and political events result in changes to IPC requirements

By Lisa Tomlinson, Nancy Hailpern, Richard Capparell and Monica Alexander

The COVID-19 public health emergency (PHE) instigated many regulatory and guidance changes from federal agencies. In addition, a new presidential administration took office in 2021 resulting in the reversal of previous Executive Orders to reduce, repeal, or not enforce federal regulations. The combination of these two events resulted in many changes to infection prevention and control requirements that were imposed on healthcare providers at a rapid pace over the last two years. This article will review some of these changes.

Occupational Safety and Health Administration (OSHA)

COVID-19 Healthcare ETS

Early in the pandemic, OSHA relaxed enforcement of annual fit-testing requirements in order to preserve N95 respirators, which were in short supply. By the end of 2020, more than 570,000 healthcare workers had been infected with COVID-19. As one of his first official acts upon taking office, President Biden issued an Executive Order on Protecting Worker Health and Safety. The Executive Order required OSHA to:

- consider whether emergency temporary standards on COVID-19 are necessary; and
- launch a national program to focus COVID-related OSHA enforcement on violations that put the largest number of workers at serious risk.

OSHA’s immediate actions focused on prioritizing inspections and enforcing existing guidance for workers deemed to be at highest risk of COVID-19 infection. In June 2021, almost 18 months into the pandemic, OSHA released the COVID-19 Healthcare Emergency Temporary Standard (ETS), focused on protecting healthcare personnel (HCP) from COVID-19 transmission. Although the goal was consistent with OSHA’s mission, by the time the OSHA ETS was implemented, most healthcare facilities had already implemented COVID-19 control procedures based on guidance from the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), Centers for Medicare & Medicaid Services (CMS), Food and Drug Administration (FDA), state and local public health authorities, and their own risk assessments. The COVID-19 Healthcare ETS was very prescriptive and sometimes based on CDC guidance which had already been updated from the OSHA requirements.

APIC’s comments on the OSHA COVID-19 Healthcare ETS recommended, among other things, that OSHA require COVID-19 vaccination for healthcare personnel, that OSHA standards require compliance with current CDC guidance, and that facilities not be penalized for compliance with evidence-based guidance consistent with their own risk assessments.

An ETS must be replaced by a final standard within six months. Realizing that it would not meet this deadline, OSHA withdrew all provisions of the COVID-19 Healthcare ETS except the recordkeeping and reporting provisions (which were already required under existing OSHA standards) on December 27, 2021. OSHA then reopened the public comment period and held an informal public hearing to gather information about occupational exposure to COVID-19 in order to develop a final standard. During the hearing, APIC Public Policy Committee Chair Lisa Sturm, MPH, CIC, FAPIC, testified to reinforce APIC’s written comments. In the meantime, OSHA is also continuing the work it started in 2010 to develop a broader Infectious Disease Standard.

COVID-19 Vaccination and Testing ETS

Although the COVID-19 Healthcare ETS directed employers to allow employees time off to get vaccinated against COVID-19, there was no vaccination requirement. In November 2021, OSHA published the COVID-19 Vaccination and Testing ETS. This required employers with 100 or more employees to require their employees to either be vaccinated against COVID-19 or provide evidence of weekly testing and wear face coverings while at work. This ETS, however, did not apply to healthcare settings which were regulated by CMS, which issued its own COVID-19 vaccination requirement on the same day (see below).

Upon implementation of the vaccination requirement, large employers, organizations, and states petitioned to stop implementation of the regulation. After several lower courts reached conflicting decisions, the U.S. Supreme Court took up the case, National Federation of Independent Businesses v. OSHA, and ruled that OSHA had exceeded its authority since, it claimed, COVID-19 is not specifically a workplace-transmitted disease. Following the Supreme Court decision, OSHA withdrew the Vaccination ETS.

Centers for Medicare & Medicaid Services (CMS)

Waiving reporting requirements

Early in the pandemic, CMS waived many of its administrative requirements to allow healthcare facilities to focus on managing the initial COVID-19 surge. This included implementing enforcement flexibility, generally limiting surveys to infection control and
immediate jeopardy complaints. Among these extraordinary circumstances exemptions was to make CMS-required healthcare-associated infection (HAI) reporting measures to the CDC National Healthcare Safety Network (NHSN) voluntary through June 2020.

In addition, CMS required nursing homes to report HAIs and COVID-19 cases to NHSN. This requirement was expanded soon after to include reporting COVID-19 facility data, not only to CDC, but also to residents and their representatives/family members.

Although the HAI reporting waivers were intended to relieve administrative burdens on facilities, results were mixed. Many facilities continued reporting HAIs to NHSN for their own internal quality control, but then realized that those facilities that continued to report to NHSN had the pandemic-period data used for payment determination. In addition, many healthcare systems and state or local health departments implemented their own COVID-19 reporting systems. Then in July 2020, HHS developed its own COVID-19 reporting system, Teletrack, bypassing the CDC. This led to confusion about multiple and conflicting reporting requirements, and unreliable data.

Quality Reporting Program updates

Again, in the spirit of reducing burden on healthcare facilities and providers during the pandemic, CMS made very few changes in the FY 2021 annual updates to the CMS payment systems for most facilities. In the updates for FY 2022 (which were published in April 2021), CMS addressed concerns about data unreliability by adopting a measure suppression policy. Under this policy Q3 and Q4 data for certain measures, including HAI reporting measures, would not be used for payment determination in the FY 2022 and FY 2023 payment years. However, the data would still be used for performance calculations and provided to facilities for internal quality control. In addition, that data would be publicly reporting on the Medicare Compare websites.

COVID-19 vaccination

After COVID-19 vaccinations became available, CMS adopted policies related to healthcare personnel (HCP) vaccination. CMS added a COVID-19 Vaccination among HCP reporting measure to Quality Reporting Programs for most care settings, requiring facilities to report on the rate of vaccination among their staff. Data would be reported into NHSN.

In addition, CMS implemented the Medicare/Medicaid COVID-19 Healthcare Staff vaccination interim final rule. Like the OSHA COVID-19 Vaccination and Testing ETS, this rule took effect upon publication and required employers to develop plans to accommodate people who could not be vaccinated because of medical or religious exemptions. The OSHA vaccination ETS only covered employees who were not covered by the CMS rule.

And like the OSHA vaccination ETS, the CMS rule also faced multiple court challenges. But unlike the OSHA vaccination rule, the U.S. Supreme Court decided in Biden v. Missouri to uphold the CMS vaccination mandate. The Court ruled that CMS has authority to impose vaccination requirement for employees of Medicare and Medicaid funded healthcare facilities, much like CMS imposes other Conditions of Participation in CMS payment programs. Participation in Medicare and Medicaid is voluntary, and facilities that choose to participate accept CMS’s rules for participating in the programs.
FEDERAL AGENCY OUTREACH

In addition to monitoring and participating with federal agencies in the rulemaking process, this year APIC is setting its own federal agency agenda to develop closer ties to key agencies that administer federal programs related to infection prevention and control.

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

APIC put together two focus groups of our members to help the FDA’s Division of Biology, Chemistry and Materials Science determine where to focus their infection control research priorities. The subject of these focus groups was the real-life challenges related to cleaning, disinfecting, and reprocessing of medical devices, including:

- Challenges in the recommended cleaning protocols and instructions for use
- Disposable versus reprocessed devices
- IPs’ and re-processors’ role purchasing decision-making
- Drying and storage of devices

APIC will continue discussions with FDA research staff as they develop research programs to determine how to alleviate some real-world IPC challenges.

ENVIRONMENTAL PROTECTION ADMINISTRATION (EPA)

APIC staff met with EPA’s Antimicrobial Division to introduce the agency to APIC and the role of IPs. Discussions focused on:

- Change in EPA product-review focus shifted from products targeting the air rather than surfaces
- Label usage
- Real world understanding of product claims
- New and changing evidence in product claims

Additionally, EPA sought input from APIC on how to best survey the hospitality and mass transit industries about educational gaps in product use/misuse and overall understanding.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

APIC and CMS Quality and Safety Oversight Group (QSOG), met to discuss APIC issues and how APIC could help QSOG in areas where our missions intersect, including:

- Defining infection preventionists and what competencies are required in the role
- APIC resources and training
- Best practices for addressing COVID-19 fatigue and human error
- Infection prevention in hospice settings
- Healthcare equity

Food and Drug Administration (FDA)

The FDA’s role during the pandemic was to encourage and oversee development of drugs and medical devices to diagnose, treat, and prevent COVID-19. In most cases, the agency expedited availability by issuing emergency use authorizations (EUA) while manufacturers continued to study the safety and effectiveness of products in real time. By the end of 2021, FDA had authorized or approved:

- Three COVID-19 vaccines for primary doses and a first booster, so that individuals ages five and older are eligible for vaccination, and individuals ages 16 and older are eligible for a booster;
- 14 therapeutics, including antiviral drugs and monoclonal antibodies;
- More than 400 tests and sample collection devices;
- More than 1,500 addition medical products, including PPE and ventilators.

The FDA also issued advisories against use of unproven and unapproved products for treatment or prevention of COVID-19, such as ivermectin, and identified and issued warnings for over 1700 fraudulent and unproven products that were being marketed for diagnosis, prevention, or treatment of COVID-19.

As the SARS-CoV-2 virus mutates, the FDA continues to adapt its authorizations based on how products react to different variants. During the COVID-19 public health emergency, federal government requirements and guidance have changed so rapidly that it has often been hard to keep up. IPs have done an amazing job working to keep their colleagues, patients, and communities safe. The APIC Government Affairs Team takes information provided by APIC members back to federal agencies to share IPC challenges and concerns. The APIC Public Policy Committee provides input on proposed regulations to ensure that regulatory bodies understand the real-world implications of the regulations they implement, and staff work to keep members up to date on regulatory changes. However, member input is essential to make sure IP needs are met.

Thoughts, concerns, and suggestions can be shared via the Government Affairs inbox at legislation@apic.org.

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 Monica Alexander is APIC associate director, Regulatory Affairs.
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When state health departments need help of their own

An interview with Janet Haas, PhD, RN, CIC, FAPIC, APIC Consultant consulting on a State Healthcare–Associated Infection (HAI) Program.

BY APIC CONSULTING SERVICES

Janet P. Haas, PhD, RN, CIC, FAPIC, FSHEA, has served as an infection preventionist and leader in the field for more than 20 years. In that time, she has built a career defined by “distinction, credibility, and prestige.” Haas has served in many leadership roles in APIC. In 2012, she chaired a newly formed APIC Professional Development Committee, which, under her leadership, started work on the development of APIC’s first IP Competency Model. That same year, Haas was appointed Section Editor of the American Journal of Infection Control (AJIC) and has continued to serve AJIC as an Associate Editor. She was elected to the APIC Board of Directors in 2014 and served as APIC’s 45th president in 2018. Haas has dedicated her career to advancing the science and practice of infection prevention and control. She is the 2022 recipient of the prestigious Carole DeMille Achievement Award.

Tell us about the State HAI Program project you recently worked on for APIC Consulting Services.

JH: I just finished a project that was particularly interesting. The task was to evaluate the HAI program of a state health department, including both the epidemiology and laboratory aspects of the program. We had a team of three experts: I was the infection preventionist (IP), and we had a public health expert, and a laboratory expert. The public health expert reviewed the grant funding and deliverables that the program needs to meet in order to secure future funding. The laboratorian assessed the testing capacity and physical laboratory space as well as the interactions between the laboratory and the epidemiology staff. I focused on staffing, workflow, data, and feedback from other professionals that interact with the HAI program.

What trends have you found in state health departments, and how does a public health program assessment differ from that of a healthcare infection prevention and control (IPC) facility assessment?

JH: Public health departments struggle with the same issues as healthcare IPs, epidemiologists, and laboratorians everywhere. Staffing, data, and communication opportunities were some of the key things we found. This is very similar to the situation for infection prevention and control programs in healthcare facilities.

One of the major differences is that public health is almost totally funded by federal grants. This means that there are grant deliverables that must be met and there are administrative functions associated with keeping up grant applications and reporting. The closest thing in healthcare would be the infection control plan that has to be revisited and revised annually.

What are some key lessons learned on how state health departments can work more effectively?

JH: I really learned a lot about how public health programs are structured, and how HAI programs fit into the overall programs. Some of the key takeaways are practices that can be used in other settings, including:

• Staffing is tough everywhere, but having an experienced IP is crucial to the success of HAI prevention and control programs.

• Hosting interns for infection prevention projects is a way to encourage budding epidemiologists and find out if they are a good fit for the program. Having specific projects for interns can help them find success in the limited duration of an internship.

• Education and training are key elements of staff development and satisfaction. This should be included in each team member’s professional development plan.

Any additional insights?

JH: I really enjoyed this project. We had a terrific project manager keeping things on track and running smoothly. She arranged meetings and took notes for some of the group meetings with the clients. The public health and laboratory experts were top-notch, and working with them was a learning opportunity for me. I was really impressed that we had a person who was able to do a thorough assessment of a state public health laboratory program and another who was so comprehensively versed with successful HAI programs practices used throughout the country. We were able to pool our talents and diverse experiences to provide this client with valuable insight and offer recommendations to improve their program. Additionally, APIC Consulting has great tools to work from in order to execute the work.

For more information about working with APIC Consulting Services, please contact Leslie Kretzu at 202-454-2611 or lkretzu@apic.org.
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Danielle DeSanty, PT, DPT, CIC, just had her one-year anniversary as an infection preventionist for Providence Little Company of Mary in Torrance, California. She received her Doctorate in Physical Therapy in 2015 from Simmons College in Boston. She worked as a clinician at Providence for the 6 years prior to the home health physical therapy setting and assisted with the infection control practices in that role. In July of 2021 she became CIC certified and currently serves as the Director of the Board as well as the Webmaster for the Greater Los Angeles APIC chapter. Danielle is an east coast native and has been enjoying the sunny west coast life for the past 13 years as a wife and mother of a very sweet, yet chatty, 4-year-old girl and a loveable, yet mischievous, 2-year-old boy. In her free time, she enjoys jogging, crafting, and baking.

What inspired you to become an infection preventionist?

I was selected for a ride along with a TJC surveyor when I was working as a home health physical therapist (PT). The surveyor observed my entire visit and kept track of my hand hygiene opportunities. I remember feeling nervous, yet confident that the visit would be a success. Unfortunately, I did miss one hand hygiene opportunity and I was devastated! I was determined to learn from this and to help others on my team. I began going on joint visits with other clinicians and educating on infection prevention strategies. I also had a baby at the start of the pandemic, and I was very interested in learning about infection prevention strategies to keep my family safe.

How has your background helped you in the IPC profession?

I do not have the “typical” background of an IP, but I believe all my previous positions have led me to where I am today. In college I worked at a roofing company, and I was the office manager and sales representative. I observed job sites and worked with contractors and field crews. After graduating with my Bachelor’s in Health Sciences I worked in outside sales for Cintas as a facility services representative. I sold cleaning chemicals and hand hygiene products for local businesses. I then went to graduate school and obtained my Doctorate in Physical Therapy, and I worked in the acute care and home health settings for six years prior to becoming an IP. All of this has helped guide me in the many facets of IP. I feel comfortable working with POM and filling out ICRAs as it reminds me a little of my roofing job. I enjoy partnering with EVS regarding cleaning chemicals and my Cintas knowledge has helped. Of course, all the clinical knowledge I gained working as a PT help with my daily interactions with patients and caregivers while rounding. Now looking back, I was more prepared than I realized for my role as an IP.

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

Overcoming the stigma that I am formally trained as a PT and not an RN, an epidemiologist, or a public health professional was my biggest challenge. There was a small part of me that felt I needed to prove that I deserved to be in this role. People were often surprised by my background training, but no one ever made me feel unworthy, it was more of a personal feeling. I can confidently say after this year and all the time and training I have put in that I no longer feel this way. I have made great relationships with caregivers and leaders. It feels like they all see me as an IP now that I have truly come into my role.

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

1. Support from my team, the IP community, and the leadership at my facility. 2. Getting my CIC early. 3. Taking advantage of all the education offered to me through conferences, courses, and webinars.

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

It was important to me to obtain my CIC to bridge the gap I was feeling as a new IP. By committing to study for my exam I was able to learn an overview of all of the major areas of IP and carry that over into practice each day. I know most do the opposite and work a few years and then sit for the exam, but taking it early helped me to understand my day-to-day responsibilities and I feel more competent in the core areas.

What is the best advice you ever received?

The best advice I have been given is from my cardiopulmonary professor, George, from physical therapy school. He told me to imagine that everyone is born with 100 marbles; each marble represents a level of aptitude within a specific attribute such as work ethic, athletic, or musical ability, and so on. Every individual can allocate their marbles as they see fit. Some may choose to put all their marbles in one category and be an expert in that field, while others may evenly distribute their 100 marbles and be a jack or jill of all trades. The point is, it is up to YOU to invest in the areas of your life you want to excel in. Always remember, it’s okay to lose your marbles from time to time, as long as you pick them up and reallocate them into the future you.

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

Embrace the challenges that come with each day. Know that it is normal to feel overwhelmed at first but take it one day at a time and eventually things will start making more and more sense. It is okay to not know things; every day, you will be learning something new and growing into your profession. Join APIC and take advantage of all the resources they have to offer. Get on as many training calls as you can. Have a passion for variety and be adaptable.
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Focus on long-term care and behavioral health outbreaks
Identify the pathogen!

BY STEVEN J. SCHWEON

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

Caram, Chen, Taggart, et al describe the ongoing, routine patient surveillance for symptomatic and asymptomatic respiratory viral infections that detected a respiratory tract illness (RTI) outbreak in a 56-room, two-floor, 120 bed long-term care facility in February 2007. All patients shared a common dining hall, smoking room, recreation room, and a physical/occupational therapy room. Fifty-two patients were enrolled during this active surveillance period. Twenty-two (42%) developed RTI symptoms. Six cases (27%) occurred on the first floor and 16 (73%) were on the second floor.

The investigators defined the RTI clinical case definition as:

- Three respiratory symptoms (new-onset, or increase in chronic cough, new onset/increase in sputum, dyspnea, chills, headache, myalgias, malaise, sore throat, or nasal congestion)
- Two respiratory symptoms and temperature greater than or equal to 38.0 degrees Centigrade (100.4 degrees Fahrenheit)

Nasopharyngeal swabs were collected from the patients and the specimens underwent culture, DFA (Direct Fluorescent Antibody) testing, and Multiplex RT-PCR (Reverse Transcription—Polymerase Chain Reaction) viral panel detection. Based on the clinical symptomology, laboratory testing, and your clinical acumen, you suspect the pathogen(s) to be:

a. *Prevotella bivia*

b. *Orientia tsutsugamushi*

c. Influenza B

d. Respiratory Syncytial Virus (RSV)

The RT-PCR detected seven cases of Respiratory Syncytial Virus (RSV), Group B, in 22 symptomatic patients. None of the asymptomatic patients were positive for RSV. One sample was positive for Influenza B. Rapid influenza testing was rarely performed in this facility.

RSV was first isolated from chimpanzees with rhinorrhea and coryza in 1956. The virus was originally named the “Chimpanzee Coryza Agent.” The RSV cellular infection results in the cell producing additional virus and cellular destruction.

The virus was renamed RSV, due to the formation of large syncytia, which is the fusion of the infected host’s respiratory epithelial cell, with adjacent epithelial cells, as seen by infected tissue cultures view with electron microscopy. RSV is distinguished by two subgroups, RSV-A and RSV-B, based upon its antigenic and genetic variability.

RSV on average results in 177,000 hospitalizations with 14,000 deaths annually among adults 65 years of age and older.

Adults infected with RSV usually have mild or no symptoms. Symptoms mimic other upper respiratory tract infections and include rhinorrhea pharyngitis, cough, headache, fatigue, and fever, usually lasting less than five days. RSV can cause severe illness, such as pneumonia, in:

- Older adults, especially those 65 years old and older
- Adults with chronic lung or heart disease
- Adults who are immunosuppressed

RSV infection can also exacerbate asthma, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF).

The CDC notes real-time reverse transcriptase-polymerase chain reaction (rRT-PCR) is more accurate than culture and antigen testing. Some tests can differentiate the RSV-A and RSV-B subtypes.

Treatment is supportive. There is no prophylaxis available for adults. Vaccines continue to be under development and there aren’t any that have met Food and Drug Administration (FDA) approval.

All seven positive RSV cases had negative RSV rapid antigen tests. Two of the seven RSV positive cases had positive DFA results. It was not possible to collect respiratory specimens from the staff.

Supportive treatment included guaifenesin, acetaminophen, and inhaled albuterol. Broad spectrum antibiotic pneumonia coverage was prescribed for two patients. Two patients were sent to the emergency department; one resident was admitted with a chronic
obstructive pulmonary disease (COPD) exacerbation and possible pneumonia. This resident developed an acute myocardial infarction (AMI), leading to congestive heart failure (CHF). The resident continued to clinically decline, was placed on hospice care, and died one month after symptom onset.

RSV can be transmitted when an infected individual coughs or sneezes, and the virus droplets are transmitted to the eye, nose, or mouth of the susceptible individual. RSV can also be spread by direct contact with infectious respiratory sections and then self-inoculation of the eye, nose, or mouth.

The CDC recommends Contact and Droplet Precautions for when caring for a patient with RSV. Eye protection is part of Standard Precautions and is encouraged in the care of all patients. Many hospitals are simplifying isolation precautions by placing all patients with suspected viral illness on both contact and droplet precautions.

However, as the COVID-19 pandemic ensues, staff may want to implement transmission-based COVID-19 precautions first, including asking the ill resident to wear a face mask, if tolerated, for source control, until the pathogen(s) is identified. The CDC notes “…it is generally safest to implement universal use of source control for everyone in a healthcare setting.” CDC also states “source control refers to the use of well-fitting cloth masks, facemasks, or respirators to cover a person’s mouth and nose to prevent spread of respiratory sections when they are breathing, talking, sneezing or coughing. In addition to providing source control, these devices also offer varying levels of protection for the wearer against exposure to infectious droplets and particles produced by infected people.”

During this outbreak, the authors note all the RSV positive patients used shared areas with no restrictions of access. Contact isolation precautions were not initiated. Also:

- Three patients continued to attend the facility hemodialysis unit
- Three patients continued to undergo physical and occupational therapy in the shared activity room

**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 contacts such as the daily and after hours phone numbers of the appropriate health department. It might be helpful to keep a copy of your facility’s outbreak policy on your personal computer/phone.


3. APIC’s “The Infection Preventionist’s Guide to the Lab” is a credible reference to enhance clinical laboratory knowledge.

4. In an LTC setting, the RSV infection risk, in addition to other respiratory infections, can be mitigated by actively promoting respiratory hygiene and cough etiquette strategies [https://www.vdh.virginia.gov/content/uploads/sites/3/2016/01/RespiratoryHygieneCoughEtiquette_FAQ.pdf].

5. RSV outbreaks have occurred in the community, hospital, and long-term care settings.

6. A recent clinical review of children and adolescents less than 18 years old who were hospitalized with COVID-19 identified individuals that were coinfected with RSV [https://www.cdc.gov/mmwr/volumes/70/wr/mm705152a3.htm?s_cid=mm705152a3_e&ACSTrackingId=USCDC_921-DM72357&ACSTrackingLabel=This%20Week%20in%20MMWR%20-%20Vol.%2070%2C%20December%202021&deliveryName=USCDC_921-DM72357].

7. RSV outbreaks have occurred in the community, hospital, and long-term care settings.
• Four patients continued to participate in therapy in the recreation room.

In summary, the authors reflected on their experience and stated the rapid antigen testing was insensitive for detecting RSV. They supported the use of RT-PCR for rapid pathogen identification. Additionally, diagnosing RSV based upon pathognomonic clinical features alone is difficult, due to the symptoms having the ability to mimic other pathogens that can cause respiratory infections.

The authors also stated the importance of rapidly identifying the pathogen and enhanced infection control methods such as hand washing, contact isolation, and implementing activity restriction to reduce viral transmission. Additionally, educating the staff with infection control measures and screening staff for viral infections will further augment the infection prevention program. A prompt diagnosis and infection prevention control methods can potentially reduce the outbreak length, shorten hospital stays, improve antibiotic stewardship, and lower costs.

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References

Steven J. Schueon, RN, MPH, MSN, CIC, CPHQ, FSHEA, FAIPC, is an infection prevention consultant with a specialized interest in acute care/long-term care/behavioral health/ambulatory care infection prevention challenges, including outbreaks.
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. More than half of these occurred outside of the intensive care unit.

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Updated endoscopy reprocessing guidelines: AAMI ST91

BY KATHLEEN MCMULLEN AND BETHANY PHILLIPS

The guidelines from the Association for the Advancement of Medical Instrumentation (AAMI) are used by many organizations to guide processes related to disinfection and sterilization. The AAMI standards board for ANSI/AAMI ST91: Flexible and semi-rigid endoscope processing in healthcare facilities recently released updates to the document, which was last published in 2015. The updates incorporate new research and improved understanding of effective processing for patient safety and the prevention of infections. Below is a summary of some of the updates. As a reminder about the structure of AAMI standards: “shall” is used to express requirements; “should” is used to express recommendations; and “must” is used when a regulator such as the Occupational Safety and Health Association (OSHA) or the Food and Drug Administration (FDA) makes a requirement. Other wording such as “may,” “can,” and “might” express permission and capability.

There was spirited discussion by the standards board about the need to modify the Spaulding Criteria to require sterilization of these high-risk medical devices. Ultimately, it was determined that this was not feasible at this time, due to the lack of sterilization options provided by endoscope manufacturers. However, the language of the standard was strengthened to state that “whenever a device is labeled to allow for sterilization, sterilization is the preferred reprocessing method.” This is in alignment with the recent post-market analyses from the FDA that showed continued elevated rates of contamination, which included pathogens, after the traditional high-level disinfection reprocessing. Per the standard, “continued research, and partnership between endoscope reprocessor and sterilizer manufacturers to support elevating the standard of endoscope processing from high-level disinfection to sterilization is encouraged.” When sterilization cannot be utilized, automated high-level disinfection is recognized as the most effective disinfection process. Alternatives such as manual high-level disinfection and liquid chemical sterilization are not recommended due to the risk of inconsistency in the quality of disinfection achieved.

Expectations were set regarding several best practices for major renovations or new construction of scope processing areas. These include two rooms to separate cleaning and disinfection/sterilization, additional clean spaces for visual inspection, cleaning verification, and designated areas for drying and documentation. Installation of hands-free equipment (e.g., foot controls, electronic sensors) for use with sinks, towel dispensers, and soap dispensers were also recommended.

Certification and training for personnel performing processing received increased attention. This iteration of the standard includes a strong recommendation for certification within two years of employment. The standard now prescribes that formal training and competency verification occurs prior to the first assignment in the processing area, and that facilities have a method to ensure staff competency and consistent compliance with procedures.

There is increased detail around point-of-use treatment which should happen at the completion of use of device whenever feasible (rather than waiting for the entire procedure to be finished), and details of the typical steps in the process to increase effectiveness. Sections on leak testing added requirements for calibration, inspection, and pressure verification of the leak testers. There is a new section on inspection after cleaning, which details required visual inspection for all scopes, new guidance on cleaning verification testing, and updated information on the use of borescopes.

Cleaning verification tests should now be performed on high-risk endoscopes (including duodenoscopes, linear ultrasound [EUS] endoscopes, bronchoscopes, endobronchial ultrasound [EBUS] endoscopes, ureteroscopes, cystoscopes, and any other scope determined to be high-risk by the facility) after each use, and for other scopes at a frequency determined by a statistically significant frequency. If a scope fails a cleaning verification test multiple times, it should be evaluated with a borescope, either at the facility of use or by the scope manufacturer. Detailed guidance for all steps in the cleaning verification process are found among the new annexes at the end of the standard.

The standard includes updated recommendations on the drying of the endoscope. There are references in the new standard that support a recommendation for a minimum of 10 minutes of forced air drying, even if the scope is processed in an automated endoscope reprocessor that has a drying cycle. Drying can be completed manually, or via an endoscope cabinet specifically designed for the drying of endoscopes. The sections on types of drying cabinets were expanded, and now states that at a minimum, conventional drying cabinets that circulate HEPA-filtered air around the scopes should be used. To date, no consensus has been met on the “hang time” of scopes, but further guidance is given on factors to consider when a risk assessment to determine hang time is completed by the facility.

Additional tools are available for IPs to use, which include guidance for performing risk assessments necessary to resolve conflicts with manufacturers’ instructions for use, as well as updated guidance for performing visual...
assessments of scopes and endoscope storage risk assessments. Some additional new sections of the standard are device repair, loaned endoscopes, and new product evaluation.

Overall, the updates increase the rigor needed by scope processing departments to ensure patient safety. IPs should familiarize themselves with these updates and be an active member of risk assessment and process monitoring teams.

Kathleen McMullen, MPH, CIC, FAPIC, is Director, Infection Prevention at Mercy Quality and Safety Center, and Bethany Phillips, MPH, MLS, CIC, is the Program Director of Infection Prevention & Control at Children’s Medical Center. They are both members of APIC’s Practice Guidance Committee.

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1. ANSI/AAMI ST91:2021 Flexible and semi-rigid endoscope processing in health care facilities.

AJIC Author Interview

BY PATRICIA STONE

AJIC Editor in Chief Patricia Stone, PhD, RN, FAAN, interviewed Elizabeth Monsees, PhD, MBA, RN, CIC, FAPIC, of Children’s Mercy Hospital, Kansas City, Missouri, one of the authors of the AJIC article, “Nurses as antimicrobial stewards: Recognition, confidence, and organizational factors across nine hospitals,” volume 48, issue 3, 239-245; doi: https://doi.org/10.1016/j.ajic.2019.12.002

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

I had the good fortune to meet Dr. Mary Lou Manning, PhD, CRNP, CIC, FAAN, FNAP, at our annual conference when she was the 2015 APIC President. I knew I wanted my doctoral work to focus on infection prevention, but I was curious where she thought new scientific contributions were needed. She shared her perspective on nursing engagement in antibiotic stewardship and I returned from the conference excited to explore this idea with the Children’s Mercy Antimicrobial Stewardship Program (ASP) Medical Director, Dr. Jennifer Goldman, MD, MS-CR. Dr. Goldman’s enthusiasm for the topic was infectious and she became a dedicated thinking partner to consider how we should systematically study frontline nurse involvement in stewardship processes. We started with an integrative review of the literature, followed by a cross-sectional survey of pediatric nurse perceptions of ASP role and confidence, which led to a nine-hospital study that evaluated frontline nurses’ understanding of stewardship clinical practices, confidence associated with those practices and the latent influence of organizational culture on their ASP participation. APIC was tremendously supportive of this work, and I was awarded the Heroes Implementation Research Scholar Award in 2019 to implement a nurse-driven antibiotic engagement tool in three hospitals. Together, Dr. Goldman and I have worked collaboratively to blend infection prevention, safety science, and ASP to reconsider how to engage a broader group of disciplines into stewardship efforts.

What spurred this focus? Why is your role important?

I was interested in ASP before many institutions had formal programs. I worked as an infection preventionist in a small community hospital in the early 2000s. We were experiencing a terrible C. diff outbreak and I did exactly what IPs are taught to do in these
scenarios—conduct a review of literature to inform practice. We implemented several new strategies as well as contacting the CDC because of the persistent outbreak. In one of the searches, I came across an article on decreasing unnecessary antibiotics, which also reduced CDI rates, a common indicator for ASP now but novel at that time. I asked our Medical Director if we should consider looking at and possibly reducing antibiotics to address the ongoing outbreak. He mentioned we didn’t have the resources to consider it—I remember being very struck by the significance of our strategies that we hoped would work, yet something that seemed so logical wasn’t feasible. Nurses, IPs, and other disciplines can identify problems in their areas of practice and raise awareness to other collaborators to begin to address those issues and work towards reformative change. Our ASP is so much stronger when health professionals and community partners share what they are seeing so we can incorporate those considerations into our programming efforts.

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

Antibiotic stewardship is such a relevant and critical safety issue for all disciplines. Antibiotics are what Spellberg et al.1 called a “shared community property or trust.” As the only pharmaceutical drug class that wanes with time and use, it is incumbent upon each of us (public included) to preserve and protect these drugs from misuse. As Manning2 et al. recognized in the APIC/SHEA/SIDP ASP Position Paper, IPs spend a lot of time with nurses and other health professionals as part of their standard work and it provides a natural connection to educate on how IP, ASP and diagnostics are intertwined for infection management.

What is your favorite aspect of your work?

I love bringing people with different perspectives and areas of expertise together. That is what is so enjoyable about the work related to antimicrobial stewardship. An effective program cannot be run in isolation. It is critical to engage many people including clinicians, pharmacists, nurses, patients, families, and data analysts to optimize antibiotic use and identify areas of improvement. Everyone has a different perspective when talking about antibiotics and it is important to understand these perspectives as we work towards aligning antibiotic use and decreasing unnecessary use.

What do you want to achieve with your work?

I want people to really think about the potential benefits and risks every time an antibiotic is prescribed. A single prescription for a common antibiotic may seem benign and it is sometimes difficult to convey why every antibiotic prescribed needs to be considered carefully. The development of antibiotic resistance may seem like a more theoretical problem. I like to focus on the importance of considering the downsides of using antibiotics unnecessarily including the development of adverse reactions like rashes or gastrointestinal side effects. It is never fun to see a patient who developed a rash from an antibiotic and end up in the emergency department requiring evaluation for the rash, especially when they didn’t need the antibiotic in the first place. About 20% of all adverse events caused by antibiotics could have been avoided as the antibiotic wasn’t needed in the first place. I want to continue to do this work so that unnecessary undesired effects of medications can be avoided when possible.

Share a turning point or defining moment in your work.

I love working with nurses but what is really rewarding is when they raise issues or concerns from practices identified in their clinical locations. One nurse manager shared how we were wasting antibiotics in patients after surgery. Our ASP Pharmacist, Dr. Anne Wirtz, PharmD, BCPPS, examined this and was able to modify order sets to reduce antibiotic waste. It was an issue we weren’t aware of but had a significant impact on care management and good stewardship of resources. I’m working with another group of vested nurses who are interested in penicillin allergies and improving documentation in urgent care settings because they recognize the importance of having clear language, so children are prescribed an optimal antibiotic, if warranted.

Is there controversy in this area?

Like others who are interested in this topic, antibiotic safety is given short shrift in clinical curriculums. So, sometimes it takes a little time to introduce the idea that nurses support the process of ensuring that antibiotics are optimized. Once we have the conversation, clinicians begin to recognize the connection between processes and how each discipline contributes to antibiotic optimization. Nurses are skilled in quality improvement so better metrics closer to what they do each day would be helpful to demonstrate the importance of their stewardship contributions.

What’s next?

First, coming from IP and safety, I’d really like to see better ASP metrics that reflect patient harm. Typical measures used are days of therapy but that fails to communicate to frontline providers how they can contribute to antibiotic safety. It’s encouraging in the ASP community there is a push to identify harm measures and we are certainly exploring this within our program. Dr. Goldman and I have retrospective review to this effect, and we have piloted impact scores for ASP recommendations. The second is developing a diagnostic stewardship program. Our laboratory has had a robust program for years on the reporting side but I’m referring to the preanalytic side of ordering or collecting. What is tremendously exciting is that this project was born out of questions from nurses on specimen variability. Based on those conversations and emerging literature we are actively collaborating with our Pediatric Intensive Care Unit colleagues—physicians, nurses, APRNs—to examine blood culture frequency, central line specimens following the implementation of care algorithm. Hot off the press is a new paper on a pediatric diagnostic stewardship collaborative that reduced blood cultures, antibiotics, and CLABSIs—we’ve been using the scientific contributions of Woods-Hill et al. to frame our work.3

References
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Coming Soon: APIC Organizational Membership

BY SARA MILLER

In late 2021, APIC members approved the creation of a new Organizational Membership offering. With this, facilities, systems, and companies can enroll multiple IPs, non-IP healthcare professionals who have IPC responsibilities, and/or other professionals through a single invoice. The program provides an opportunity for organizations to ease the payment process and access new benefits.

“Organizational Membership” describes the facility/system/company. This new membership category supplements APIC’s existing individual membership options. Individuals covered by Organizational Membership must still meet the current definition of the appropriate individual membership category. And, as it is now, voting and volunteer eligibility is determined by the member type.

Benefit Access for Individual Members

Individuals covered by an Organizational Membership receive the full suite of APIC benefits. They will have their own unique membership ID and account, which they’ll use to access member-only communities, register for events, and read online publications.

Existing members added to an Organizational Member roster will maintain their current account credentials and history. The one big change is that you’ll no longer receive an invoice and renewal reminders. (That sounds good, right?) Billing will now be coordinated through your Organizational Membership administrator. In short, you won’t see any difference in benefit access or coverage whether you’re an individual member or your membership is covered by an Organizational Membership.

Organizational Membership Pricing

Pricing is based on tiers with a defined number of individual memberships. The smallest tier is 6-10 members. Pricing is at least a 10% savings on the maximum number of individual memberships per tier.

When considering which tier is right for you, you’re encouraged to reach beyond your immediate team. Whether it’s the C-suite, EVS, or someone considering transitioning to IPC, think broadly about who would benefit from APIC’s resources.

You can also decide if you want to enroll at the headquarters/system level or leave it with each facility. Although the savings increases with higher (larger) tiers, budget structures may dictate how your organization can participate. APIC will work through the options with you.

Benefits

In addition to the savings and convenience of a single invoice, Organizational Members receive additional benefits, including:

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change, we can transfer the remaining months of membership to the new employee.

- **Promotion on APIC.org:** All Organizational Members will be promoted on APIC.org and other communication channels. You will also get a special badge ribbon at APIC’s Annual Conference to show your Organizational Membership status.

- **Custom webinar:** For Organizational Members at the 50+ tier, APIC offers a custom welcome webinar with member leaders to introduce your team to APIC and their new member benefits.

As the program progresses, we expect to offer additional benefits to Organizational Members.

**Timeline**

The pilot program launched in January. Although we are still finalizing a few procedures, APIC is actively enrolling organizations in this new membership offering. The full program launch is scheduled for Summer 2022.

**Want to learn more?**

For more information, visit our website ([https://apic.org/organizational-membership-type/](https://apic.org/organizational-membership-type/)). If you’re interested in signing up or would like to be notified once the program is live, please contact membership@apic.org.

*Sara Miller, MBA, CAE, PMP, is senior director of membership at APIC.*
As Infection preventionists (IPs), we support evidence-based practice interventions to improve mitigation efforts on infectious disease transmissions and the prevention of healthcare-associated infections (HAIs). It has become every IP’s responsibility to engage in some form of research. The Certification Board of Infection Control and Epidemiology (CBIC) core competency model includes research as one of the six professional and practice standards for IPs. But between conducting rounds, monitoring practices, routine surveillance, transmission investigations, and committee participation, a focus on research and advancing the IP profession is left at the bottom of the IP to-do list. Daily responsibilities of an IP span a wide range and we are often left with little time to dedicate to research requests.

Something that is fairly common in the software engineering practice is a “code freeze” or “convergence period” which allows engineers to shift gears and work on quality or “nice to have” fixes that aren’t necessarily requirements. Driven to give the IPs in our healthcare system an opportunity to conduct or participate in research, our team created “research office hours” that are held at least monthly to discuss ongoing research strategy for the IPs, including current project work or scoping for future projects. The office hours were built upon five key facets, or five C’s: communication, convenience, collaboration, coaching, and competency.

Communication

Our infection prevention program typically sets a goal each year for the individual IP to meaningfully contribute to their profession in some way. This includes submitting an abstract or manuscript for publication, hosting education sessions to frontline staff or other IPs, participating in local governance of APIC and holding office within a chapter, or presenting a poster at a national forum. By setting these as individual goals, we are communicating to all IPs that research is important and should be integrated into their workflow.

Convenience

In an effort to reach some of these goals, there are two hours designated a month during the work day for the IPs to scope out their research ideas and projects. This group is facilitated by two IP directors during the work day virtually to provide opportunity for any IP to join. It offers flexibility to an IP and gives them the capacity for research. Anyone can join to listen and learn about how they can develop their ideas into a project or publication. Opportunities are often presented in this group, such as a rolling local conference list and abstract submission dates.

Collaboration

Connecting with appropriate subject matter experts who can actively participate in designing and implementing a project helps ensure facts and details are correct. IPs in this diverse group are able to provide and receive feedback on how a project makes sense, including constructive and meaningful feedback that helps reframe their research and make adjustments where needed. Realistic timelines are often a challenge in research and having that outsider’s view helps with feasibility and project scoping. Discussion of current workflows or practices is also brought to this group and can inspire efficiencies such as building in automation where possible.

Coaching

Experienced IPs are available to discuss impact and scope of the research brought to the group. Broadening the scope of a project offers cross functionality and could impact more local or system clinical departments. Formulating or validating a design decision also allows for IPs to ask important questions about what problems they want to solve in their project. We also want to ensure the IP has the ability to set their projects up for success using time management skills and providing a support system to ensure they can make space for their project on their busy calendars. Novice IPs may not have the tools or background to showcase their projects. This group provides mentorship and information on steps to submitting a publication to a journal, as well as resources and templates for stepping stones to their contributions.

Competency

As part of APIC’s Future-Oriented Competency Domains, research feeds into the annual competency of an IP as set by the program. At a minimum, IPs are expected to be knowledgeable of prevention research and to read and interpret scientific writing to describe objectives, methods, and results in an effort to stay up to date on relevant findings that may affect their organization. Producing that research, leading research activities, or engaging in the development of projects enhance an IP’s career and can improve the professional practice.

The main benefit to a subcommittee or regular focus group is that it allows staff to safely shift gears in regards to their priorities. This dedicated work time allows them a chance to address any backlogs that may have popped up and to advance project work. Taking that reset time allows the IPs to rest the part of their brain that is focusing on their main deliverables. Ultimately, patient safety is improved and better, more efficient evidence-based practice is inspired and created.

Grace Barajas, MS, M(ASCP)℠, CIC, FAPIC, and Christina Silkaitis, MBA, MT, CIC, FAPIC, of Northwestern Memorial Healthcare.
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The World Health Organization (WHO) declared SARS-CoV-2 a pandemic on March 11, 2020, a day many in infection prevention and control (IPC) will never forget. Within a matter of weeks, millions of workers quickly adapted to virtual meeting platforms, and society complied with new behaviors such as sheltering in place, use of social distancing, and donning masks to protect others. The rapid adoption of societal and healthcare behaviors and their impact may not be fully understood yet, but it does beg the question: Were our pre-COVID-19 pandemic readiness plans sufficient? For instance, our recent memories of SARS, MERS, and Ebola were events requiring planning and even presented preparedness opportunities for adequate policies for healthcare worker safety, yet due to the scale of the COVID-19 pandemic, evidence thereof was lacking. Several immediate measures to mitigate the risk of COVID-19 transmission included measures to restrict societal movement socially and within workplaces, precipitous vaccine development, and dispersion plans, testing strategies, contact tracing, and an emphasis on personal hygiene and protective equipment. Pre-COVID-19 pandemic plans, while drilled many times into us, may not have been adequate for the sheer scale and rapid escalation that occurred and sustained at different thresholds for nearly two years. As COVID-19 community levels decrease, de-escalation of the prevention strategies needs to occur with a transition to what may become the new normal. What has been learned during this pandemic is that social distancing and societal restrictions added stress not only to economic factors but to the physical and mental health of the population at large. No doubt infection preventionists (IPs) recognize there is a balance that needs to occur. De-escalate too fast and transmission risks increase; too slow and economic and/or human stressors occur. However, it is important for COVID-19 plans, responses, policies, and lessons learned be collated and used for escalation for a new variant or the next emerging pathogen. It becomes a continual cycle of planning.

What skillsets did the IP utilize during the pandemic?
To expand IP competency further, the pandemic response stretched the role of the IP and required a rapid evolution of skills and interaction with many leaders and key stakeholders. To better contextualize this outcome for better understanding, the use of the APIC Competency Model as a framework will be used (https://apic.org/professional-practice/infection-preventionist-ip-competency-model/). For background, the 2015 APIC MegaSurvey results illustrated the variety of backgrounds existing within the IP role, which includes those from a laboratory background and that of public health. This diversity exemplifies how a novice to expert IP should progress, and the COVID pandemic is a great demonstration of how the IP functions through this model and its subdomains. To stay current and meet the needs of contemporary IP practice, the six domains include:

1) leadership,
2) professional stewardship,
3) quality improvement,
4) IPC operations,
5) IPC informatics, and
6) research.
Various examples are discussed here and an understanding thereof, within this framework can assist the IP upon further competency development. For instance, IPs had to become health system leaders, even if they were not in official leadership roles. No longer were IPs seen as forgotten healthcare workers in a small, isolated office. They had to be clear communicators, collaborating on teams from the c-suite to the bedside, inpatient to the community, utilizing their critical thinking and subject matter expertise fluidly. IPs had to become informatics experts in some settings to ensure that there was visibility of who was a PUI and how that was communicated in the EMR as well as with outside collaborating partners (public health, non-health system healthcare organizations). C-suites were now interested in an abundance of pandemic-related data and charts and IPs were building these requested reports or working with data analysts to have large amounts of data available at stakeholder fingertips in a moment’s notice. New testing techniques and equipment were available and the IP had to evaluate advantages and disadvantages of each quickly. IPs became skilled at when to speak from scientific evidence or at least be aware there may not be any. Immersion into implementation and dissemination science occurred despite many IPs not being cognizant that such approaches existed [https://apic.org/course/research-webinar-series/]. The IP had to adjust normal operations by shifting surveillance practices, focusing on epidemiology and outbreak management as exposures needed investigating, staying current on latest COVID best practices, and managing the supply chain challenges and allocation limits which included diagnostic testing. Quality improvement was never out of the mind of the IP, as they had to focus on remaining a subject matter expert, not just in areas such as HAIs or cleaning, disinfection, and sterilization, but in this pandemic and each emerging variant. Although COVID was a focus for many, patients still remained in the healthcare setting, so the IP continued to have to work on performance improvement initiatives and risk assessments to ensure patient safety was not compromised in the shifting environment. Finally, the IP needed to continue to practice appropriate professional stewardship, remaining accountable, and being an advocate for patients and staff despite the numerous challenges already highlighted. COVID has brought to light how new infections can truly hit different populations differently. How COVID impacts the continuum of care continues to be seen and the longevity of such impact is yet to be determined.

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De-escalating the COVID-19 response: An infection prevention perspective

The “Great Resignation” certainly has hit healthcare in a very dramatic way and has not spared infection prevention departments. Just when we needed the most help, many were overwhelmed with the notion of how to utilize temporary staff or train newly hired IPs with little or no experience. We need to be agile in our onboarding and creative with our approach to accomplishing the goals of the infection prevention programs in our facilities. As people re-evaluate what is important to them in general, they are also advocating and vocalizing the need for change—challenging not only “what has always been done” but also how it is done.

Utilizing virtual technologies has allowed workers from all sectors to perform critical functions of their jobs remotely. Building upon that framework, IP departments could identify functions that could be potentially performed by a group of centralized staff to support several facilities within a healthcare network to cross-level experienced staff and share workloads.

By utilizing the APIC Competency Model, several examples related to key domains and subdomains relevant to our new normal are exemplified:

Professional Stewardship:
Accountability—It is necessary to demonstrate that accountability measures are in place. PPE audits are no longer just for goal setting, but integral in ensuring compliance with regulations designed to ensure the safety of staff and patients/residents.
Population health—Evaluations of risk no longer begin at the entry to the healthcare facility, but rather must factor in community health as a whole and the healthcare system’s interaction within the community, as evidenced by the relationship between COVID-19 community transmission levels and mitigation strategies required within facilities.
Continuum of care—Understanding the importance of the setting of care on the individual risk factors for a patient as they move throughout the continuum of care. Ensuring communication between levels of care has never been more important—especially with contact tracing, notifications, different recommendations for length of isolation/quarantine between settings.

IPC Operations:
Emerging Technologies & IPC Rounding—Just as virtual meetings have become a mainstay, utilizing virtual technologies for keeping patients connected with loved ones to reduce the risk of in-person visitation has become more than just a temporary solution. Using virtual technology to complete environment of care portions of regulatory surveys has been increasingly more common due to the necessity for continuing operations during COVID. Becoming adept at using virtual technologies is an important skillset that can be leveraged to perform rounding and site inspections remotely.

“Normal”, what is it beginning to look like?
With numbers of new cases of COVID-19 decreasing in much of the country, there is talk of what an endemic approach to COVID-19 would look like. These conversations include using the marker of community prevalence of infection to determine mask mandates, social distancing in public, approaches to in-person or virtual learning and other aspects of our pandemic-related life. Within IPC this new normal has boundaries for flexing up or escalating our practices in anticipation of another wave and scaling back or de-escalating when numbers of hospitalized patients are low; this requires flexibility in doing so. It is important to note, however, healthcare professionals may prefer standardized clinical processes from trusted sources in this post-COVID-19 era; therefore, a rapid cadence of implementing guidance may be needed. Still a bit shell-shocked from the Omicron wave in the beginning of the year, this period with very few cases feels surreal and leaves many of us feeling anxious and unsure. We are frequently checking community prevalence rates in our local counties to inform our need for additional mitigation measures and quietly celebrating low rates of infection while still reminding our colleagues that the pandemic isn’t over.

Normal for IPC now includes resuming pre-pandemic focus into healthcare-associated infection (HAI) prevention and environmental rounding while keeping an eye on COVID measures and updated guidelines for vaccines. It involves returning to in-person meetings while still wearing masks and advocating for distancing. It centers on evaluating what we’ve learned about virus transmission and optimizing PPE use and applying those concepts to other transmission-based precautions. In many ways our experiences over the past two years have improved our biosafety preparedness and incident command structures, optimized our communication techniques, and highlighted the value of our profession.

We have grown and stretched from the pressure of the pandemic with many of us learning new skills and developing new relationships due to staff changeover. Growing new IPs is never more important than now as we navigate this new time.

In summary, the COVID-19 pandemic response catapulted IP skills and competence thereof. Utilizing the APIC competency framework along with a personal and departmental inventory of the response can be a positive approach to your role moving forward and useful to the next cycle of planning, escalating, and de-escalation of any situation. Innovation often takes years, yet the COVID-19 response and escalation illustrated the rapid speed of learning and innovation that was needed immediately and this approach may become the “new normal.” IPs should take the time to contemplate what skills were learned and continue to enhance and apply to IPC daily work. Leveraging your team’s decision-making structure and processes learned during the COVID-19 response escalation should be captured and used for the continual phase of planning, escalation, de-escalation, and creating what might be the “new normal.”

References

Amelia Cleland Bumsted, DNP, CIC, FAPIC, Maggie Reavis, MPH, RN, CIC, CPHQ, Shelly Reheard, MSN, RN-BC, CIC, and Chris Zirges, DNP, ACNS-BC, CIC, FAPIC, are members of APIC’s Professional Development Committee.
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Fostering the next generation of infection preventionists during a pandemic: Mentor and mentee perspectives

BY HANNAH BATTEY AND BRENNA DORAN

HANNAH BATTEY, MENTEE
It was the beginning of October 2019, and I had just moved back to Southern California after completing my master’s degree in human biology at the University of Copenhagen in Denmark. I was bright-eyed and excited about beginning my career in infection prevention—a goal I had set for myself during my graduate studies. Unbeknownst to me, landing a job as an infection preventionist (IP) was not going to come easy.

Two months later, my child-like enthusiasm had been replaced with frustration and fear of checking my email and seeing yet another “Thank you for applying… but we decided to move forward with a more qualified candidate” message. Despite the endless job applications and cover letter revisions, my applications were consistently landing in a black hole of rejection. When a kind soul did provide feedback, I was told, “We are looking for a Registered Nurse (RN).” “Sorry, but you need 3-5 years of experience and your certification in infection control (CIC) to even be considered,” or “Master of Science? That background doesn’t apply to this job description.” It quickly became clear that in order to be considered for an IP role, one needed experience in infection prevention or be a registered nurse. To put it simply, I didn’t meet either of these two criteria. However, I knew that my education and research background contributed valuable knowledge and practical application for the role. After all, I had spent the last six years studying infectious disease pathogenesis. Surely that meant something, right?

What I soon began to learn was that candidates with a master’s in public health (MPH) and microbiologists alike were also experiencing the same biases and barriers to being considered for the IP role. Seeing as the nursing route was not a feasible option, the only option appeared to be pursuing the IP experience. But how does one get that experience? Volunteer? Intern? What does enough experience look like? How do I find an infection prevention program that might work with me? I was toying with the age-old question of how one is supposed to gain professional experience without the opportunity of said professional experience. See Brief on p. 14 on APIC’s newly created, Accelerated Internship Program Guide for IPC.

During this downward spiral, I stumbled across my first glimmer of hope (I would later come to realize that this hope was quite literal—City of Hope Medical Center). Doing my best to think outside the box, I developed a LinkedIn messaging technique wherein I messaged as many IPs as I could find in Southern California, introduced myself, and asked if they knew of any opportunities or were looking for extra assistance. More often than not, this resulted in radio silence. Occasionally I would get a response, “No, thank you, but good luck.” As a committed optimist, I knew it only takes one person to change everything. My faith was validated when one of the messages I sent into the abyss responded, “Give me a call.” Those magical words immediately led me to pick up the phone and make that call. The IP answered, and he asked about my background. He apologized for not being able to help me, but my story reminded him of someone he knew who was also an IP, Brenna Doran. “You two have a similar background, and there’s a fire in you that reminds me of her…try sending her an email.” I promptly sent Brenna an email describing my journey and shared the challenges and barriers I have been trying to navigate. She asked me what I wanted and how she could help. I said, “I want to be an IP.” “Okay, then let’s get you experience in the IP environment as a volunteer. Are you willing to move to Duarte?”

BRENNA DORAN, MENTOR
When I read the introduction email from Hannah, it reminded me of all of the challenges and roadblocks I experienced back in 2011 when I wanted to become an IP. At that time, nearly every IP I knew was an RN. It wasn’t until I met an IP with a bachelor’s in biology that I even knew the role could be done by someone other than an RN. When I became interested in transitioning into a role in infection prevention in 2010, I was a clinical microbiologist at a pediatric hospital and had a master’s degree in education. I was fortunate that the IP program at the hospital I worked at was willing to allow me to volunteer to gain some experience so I could successfully apply for a position. So, I began my infection prevention journey with a volunteer opportunity and spent nearly nine months volunteering until I was offered my first role as an IP.

I was fortunate that I had been a mentee myself and had experience training newcomers in infection prevention. This allowed me to build a template of what basic infection prevention skills Hannah would need, leverage her education and research experience, and build a plan to fill in her gaps. Before I could bring Hannah on campus, I had to connect with our education and volunteer departments to identify if I could get her in as an intern or if I would need to bring her in as a volunteer. Hannah was not presently a student at an affiliated university, which excluded her from qualifying as a graduate intern. From there, I
HANNAH BATTEY, MENTEE

At the beginning of January 2020, I pulled up in a U-Haul to the apartment I had found on Facebook marketplace (a building that I had yet to step inside of before that day) and began to set up a new home. As excited as I was to have the opportunity to gain experience in infection prevention at City of Hope Medical Center, I was volunteering and still needed an income. I secured three part-time jobs to work around my volunteer schedule. In my free time, I would read whatever guidelines Brenna recommended to help provide me with a foundational knowledge of what healthcare-associated infections (HAIs) were, how they were defined, and the various guidelines to help prevent them. When I started volunteering, I spent my time rounding the facility, learning the roles of different departments and how each was involved in preventing infections. It was, at first, an orientation to the world of infection prevention and cultivating an IP lens. Brenna asked me many questions I didn’t know the answer to and then provided me with well-thought-out responses, which broadened my understanding. Little did we know, there was a big surprise in store for us.

BRENNA DORAN, MENTOR

Before Hannah began at City of Hope, I spent time creating a loose training plan. The goal was to cover the core topics of infection control with sufficient depth to prepare her for an IP position, with collaboration and relationship building taking a top priority (Figure 1). During the first month, the focus was on exposure to the inpatient and outpatient environment, patient populations, care provided, and how infection control partners with each. However, by the end of February, I had an inkling that my original plan for Hannah’s orientation may need to become flexible to accommodate what was coming. We began spending considerable time educating staff, providing COVID-19 updates, and creating processes for when COVID PUIs (persons under investigation) came through our doors.

HANNAH BATTEY, MENTEE

In January 2020, the whispers of a novel coronavirus in China evolved into loud, anxious chatter as the Wuhan virus made its way into the United States. By March 2020, the country was beginning to shut down, and I lost all of my part-time jobs. Gobsmacked at the abrupt turn of events and suddenly with lots of free time on my hands, I started coming to City of Hope daily to support the IP team and be part of the pandemic response in real-time. I was rounding the facility daily, providing updates from the Centers for Disease Control and Prevention (CDC) website and training on correctly donning and doffing personal protective equipment (PPE). After weeks of volunteering full-time, leadership recognized my value and lack of income. Brenna presented a case to leadership to create a paid internship to allow me to stay full time and pay my bills. Annemarie Flood, the senior department manager, was able to then present the case to senior hospital administration. With the work of multiple invested people, they were able to secure a six-month, paid internship opportunity for me. During the internship, I assisted with COVID-19 reporting, staff education, contact tracing, rounding, HAI surveillance, NHSN reporting, and implementing a hand hygiene improvement campaign.

Figure 1: Introductory Infection Preventionist Training Framework

Establishing the mentee opportunity and setting expectations

• Determine whether there is an opportunity for funding your prospective mentee. If not, investigate whether a volunteer can be brought into the department. There likely is not an existing IP volunteer position, but you can discuss the options available with Volunteer Services. Be mindful of the institution’s policies on PHI and the duties permitted within a volunteer role.

• Create a contract detailing the number of hours to be expected and realistic goals and learning objectives that can be achieved. Understand what both the mentee and mentor want to leave the experience with.

• Discuss whether there are known opportunities to extend engagement or advance from a volunteer to a paid internship or paid IP/data analyst role.

• Complete an initial skills assessment to determine the mentee’s strengths and opportunities for training and education.

Implementing the mentee program

• Demonstrate the importance of building and maintaining strong interdepartmental relationships. This is one of the most essential elements of the IP role. Create opportunities for the mentee to interact, collaborate, and partner with staff.

• Implement a hybrid approach to learning, wherein the mentee has time to absorb new information and practice the knowledge learned on the job. For example, have the mentee read environment of care guidelines and then take them on rounds and test their knowledge. Ask them to outline their findings in a report and provide constructive feedback.

• Take advantage of free learning resources and certifications that can help the mentee build their resume.

• Connect regularly to discuss goal progress and what is or is not working. Adjust timelines and goals accordingly.

Closing the mentee/mentor loop

• Complete a skills assessment to identify areas of growth and areas where additional support and focus is needed.

• Discuss what went well and how the mentee can leverage the skills and experience towards interviewing for a paid IP role.

• Maintain open communication with the relationships that were established during the experience. If strong relationships were made with certain departments, a collaborative recommendation can go a long way.

• Offer a letter of recommendation or professional reference at the end of the engagement.

• Determine whether there are any opportunities available at the institution to support an additional IP and if not, does the mentor have any contacts or resources to provide.

Figure 2: Recommendations and Considerations for a Successful Mentee-Mentor Experience

continued on page 54
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In 2002, APIC celebrated its 30th anniversary. Then APIC President Gigi Dash, RN, RGN (UK), BSN, MS, CIC, spoke in Tennessee at APIC’s annual conference on APIC’s successes and challenges so far. Below are some of the highlights from her speech. You can view the slideshow and speech on APIC’s History Timeline, available at https://apic.org/50th-anniversary-timeline/.

Carole DeMille was a pioneer of the profession and one of the founders of APIC. She was APIC president in 1975 and 1976. Carole passed away in 1979 but her legacy of service lives on in the Carole DeMille Award. In her first APIC Presidential Address, Carole shared these words:

Please keep in mind, all of the people working to build APIC are people just like you. They all have full-time jobs, are volunteers, and are trying to build for the future of this organization. If you are ever tempted to say, what is APIC doing for me, remember that APIC is you.

In 1973, APIC published its first newsletter. Then Editor in Chief Julie Garner had this to share:

The newsletter was typed by a friend, was printed on 8.5 x 11 in paper by a printer that I found in the yellow pages of the Atlanta telephone directory.

In 1972, Shirley Bradley, an infection prevention practitioner, designed the first APIC logo. She said of the logo:

The chain encircling the letters of APIC represents people joining together for the purpose of communication in the field of infection control. The chain also serves to remind us of the significance of breaking the chain of transmission in the control of infection.
The editor in chief of the first APIC Curriculum for Infection Control Practice was Barbara Soule in 1983. The book was 1,000 pages and 49 authors contributed to its development. Barbara said when she couldn’t sleep at night, she would get up and work on the text on an electric typewriter and with correction fluid.

1985 was a milestone year for APIC. Then APIC President Dr. Bob Sharbaugh worked hard alongside staff and members to get President Ronald Reagan to sign a Presidential Proclamation declaring National Infection Control Week.

Under the leadership of Dr. Bill Rutala, the APIC Standards Committee became the APIC Guidelines Committee. The first two topics chosen for guideline development were: use of antimicrobial agents by Elaine Larson, and Selection and Use of Disinfectants by Rutala.

In 1993, APIC changed its name to the Association for Professionals in Infection Control and Epidemiology, to reflect the expansion of scope of practice.

For 17 years AJIC was edited by Dr. Mary Castle White, followed briefly by Dr. Bruce Hamory. In 1996 Dr. Elaine Larson became editor in chief of AJIC and under her leadership the review board expanded and the journal became international.

In 1996, the APIC website was launched.

For more APIC member reflections and memories, go to https://apic.org/about-apic/history/. For a full timeline of APIC’s history, go to https://apic.org/50th-anniversary-timeline/. Prevention Strategist thanks Gigi Dash for sharing her speech with APIC.
Recently, APIC leaders had the privilege to interview Kay Wenzel Owens on her career as the first known “Infection Control Nurse” in the U.S. and her role as APIC founder. Following are highlights of that conversation.

On her entry into infection control and prevention:

In 1961, I was working on cancer research and general surgery wards at Stanford Hospital. In 1963, professors in the infectious disease division of the medical school noted a paper in the British literature about an “Infection Control Sister” and thought it was a good idea for hospitals here as hospitals in the 50s and 60s were battling Staphylococcus infections. They adapted that idea and proposed having an infection control nurse at Stanford. They recruited nurses and ended up with me.

They told me the role would be about case finding, surveillance, in-service education and reporting. So I would start each day in the infectious disease lab with pertinent lab reports before visiting the nursing units (wards). I talked with the nurses in charge and reviewed post-surgical patients and fever charts looking for clues. I reported to the ID professors when necessary. I did not report to anyone in nursing service but worked closely with many of them. I also compiled all the data for the monthly infection control meetings.

In 1967, there were a few more nurses like me and Claire Coppage. The CDC had started week-long training classes twice a year in Atlanta. I published a paper on the Role of the Infection Control Nurse/ Nursing Clinics of North America in 1970. I was an active participant in the early training courses at CDC and then a part of the teaching staff until December 1972. (Ed. Note: Kay’s life and involvement with APIC changed abruptly in December 1972 as a result of a catastrophic accident in Italy that killed her husband and required months of hospitalization, surgeries, and rehabilitation for Kay.)

On meeting at Burroughs Wellcome in the Spring of 1972/ Raleigh, NC:

I don’t recall all the details, but Pat Lynch said in her 40th anniversary comments that in the first 3 days we accomplished so much.

We were all so excited to get this going! We established the organization and the committees and the logos and the officers and a plan. I do remember long days and lots of interesting discussions. The participants were selected by Claire Coppage from the classes she held at the CDC: Fellow APIC founders Grace Emori and Julie Garner and Pat Lynch and Carole DeMille, all being very good friends.

Claire started these training classes and selected two participants from each class that she thought would succeed on the steering committee. She was the motivation for all of it. Her mission was to get this group created and started, but I think that the benefit was not just for nurses who chose this path but also hospitals because IPC has been shown to make a difference in terms of quality of care and nosocomial infections. Most people in the 60s did not know that word, and it is still true, as we all know. I tell people, yes, hospitals can be very dangerous places. I think once hospital administration understands the critical aspects affecting the quality of care, they are very supportive.

Pat Lynch was elected the first President and I was elected President Elect, not knowing what the very near future held. Pat mentioned that we all chipped in twenty dollars to get that first educational meeting going in
Toronto. Imagine, the membership was 640 and now it is over 15,000. Wonderful! I was able to return to work part time in 1973 and so was able to attend the first educational meeting in Toronto and I was the scribe.

I was awarded the Pioneer Award in 1975 at the APIC Annual meeting in Chicago for being the first infection control nurse in the U.S. that we knew of.

In February 1975, I retired, married Wally, a widower with three teenage boys, and moved to Southern California, and that is why my time being active with APIC was relatively short. In 1997, I along with the other 19 members of the original APIC Steering Committee were awarded lifetime memberships to APIC.

**On the use of technology in infection prevention and control:**

First of all, the word “computer” terrified me in 1963 or perhaps later.

I attended a class in the medical school to learn about the new IBM 360, I think. The computer was enclosed in glass, outside and the size of an apartment. It was a major challenge. The terminal I used was in the ID lab. Eventually we all know what happened with that. I’m not an IT person but could see what some of the smarter people were doing with it and thought, this will work!

**On the evolution of the profession and the IP role:**

It wasn’t too long, a few years, before I had an assistant, and now some IPs are managers with two or more employees. In my time, that did not happen. Also, just by reading the literature, it was clear that microbiologists were becoming part of the IPC team and were equipped to adapt to the role rather well.

The teaching part of the role was rewarding, sometimes formal but many times not, it was ‘of the moment’. In medical school, aseptic practices were not included, so I met with the students regarding such procedures for isolation and protective/reverse isolation before they ventured on the nursing units. Also, these classes were part of the orientation for such departments as housekeeping.

**On collaborating with challenging personalities:**

Have a soft touch. Go at it from “the back door.” Don’t confront people with information they do not want, or helpful procedures they don’t want to hear about. You just have to charm them. Success in any field is dependent on how you relate to people.

**On the future of APIC:**

When you get a group together, everyone has something to say. It is invigorating for me to hear and know that the work goes forward as I see today from my interviewers. Such a pleasure to meet all of you and realize APIC is in such good hands and tuned to go forward on all fronts. Thank you all for this opportunity.
On April 12, 2022, APIC President Linda Dickey, APIC CEO Devin Jopp, and APIC’s Vice President of Communications, Marketing, and Practice Resources Liz Garman, interviewed APIC’s first president, Patricia Lynch. In her own words below, Pat Lynch describes her journey into infection prevention and control and the early days of APIC.

Pat Lynch:
The way that the University of Portland Scholarship Nursing program worked was by enrolling us in a nurse’s aide training program for three months following high school graduation.

Then we got to work for the hospital 20 hours a week and that provided enough money for food and books and whatnot. I had an epidemiology teacher who was absolutely fabulous and so I kind of caught the ideas real clearly of what he was talking about and thought at the time.

But of course, when I graduated, I went straight into Med Surg, like most of us do. And then I found reasons to get interested in epidemiology again. I took a position as a nursing supervisor with Group Health Cooperative of Puget Sound. At that time, they were one of eight participants in a large and very intensive study that was coordinated by the CDC and partly funded by the American Hospital Association. The point of the study was to collect very large amounts of data about hospital infections and to be visited three times a year for three years by a team from the CDC who would do a prevalence survey. That is, they would review all of the charts of all of the patients in the hospital, find all of the infections, and gather all the data on antimicrobial use.

So that’s how I actually started an infection control.

In the 1960s there were a lot of things that fostered what were then known as hospital-acquired infections. There was this terrible architecture of mid-last century, very large wards with a sink at one end and a sink at the other end and an open hopper for bedpans and the like. There were a considerable amount of shared supplies.

For example, there was a linen closet which held all of the blankets for all the patients in the ward. Most wards were six to ten beds and they all shared their blankets and pillows. They also shared supplies in a way that was really not safe, although we didn’t understand that at the time. For intermittent positive pressure machines, we changed the mouth pieces in between patients. But nearly all the patients on the floor—which would have been about 40 patients—used the same machine. So there was a lot of sharing that went on, which would be unimaginable now.

There was not enough handwashing. And of course, there was no alcohol-based hand sanitizer. Patient care practices, like single use items, didn’t exist.

There were very long patient stays, and hospital infections were actually a source of

“The dream was that every hospital within a few years would have an infection control program staffed at least part time by someone who had received some training.”
We were confident that APIC, once it was a fully functioning organization, would be able to make a great deal of difference within a few years.”

revenue for hospitals at that time because they lengthened the patient’s stay even longer. And so insurance companies paid for them. Then there was really poor education for physicians and nurses in medical school and nursing school about infection prevention.

The other thing was there was really inadequate and inconsistent identification of organisms—the Kirby Bower method for antibiotic resistance was not fully implemented, and there were many errors in identification. So there were a lot of problems on the patient care end of things.

Additionally, there was nobody appointed to do anything with infection prevention and so even when there was really interesting new data coming, there was still nobody there to do it. In about 1964, a staphylococcal epidemic started that turned into a global pandemic.

The patients who were most affected were nursery babies, because the length of stay was so long. Babies stayed pretty much a minimum of five days. And so did their mothers, for that matter. The organism was still penicillin sensitive, but very difficult to manage. It created immense problems in hospitals all around the world and went on for three years, give or take. And so there was a lot of ferment in the air about hospital infections and what should be done about them.

Right toward the tail end of that, in 1965 I believe, President Johnson signed the Medicare and Medicaid bill. So there was funding going straight into Medicare for paying bills. And the huge variability in care just really knocked the whole program for a loop. From that, studies were done to come up with a process for combining patients with similar diagnoses or similar surgical procedures into groups so that the bills could be paid by group rather than by all of these individual things.

So once everybody got patients placed into diagnosis-related groups, there was still huge variability in length of stay for the patients and bad outcomes. They decided not to pay for hospital infections, thinking that that was perhaps something that the hospital should bear the pain of. And this sort of thing went on for several years.

By 1968 or ’69, Claire Coppage and Jay Sanford at CDC were teaching a course on infection prevention called 1200G. Claire asked each graduating group to vote for two members of their class to be nominated to be on a steering committee.

Claire Coppage was utterly confident that she would be able to find funding for a meeting of the steering committee, and that infection prevention was going to be a major and partially solved issue in the next five years or so. She did get funding, and so the original steering committee was made up of faculty from 1200G, and the participants that they voted for. She got funding from Burroughs Wellcome for a committee meeting over the weekend at Research Triangle Park. Our task was to form an organization that could address both ends of the issue, that is affecting patient care practices to get a better outcome, but also to receive information from outside and manage the program in a way that new things could be introduced and implemented. And that’s how APIC started.

“It was a two and a half day meeting, started early, ran late, and the idea was to have the structure of the organization and its tasks laid out by the end of the meeting.

All of the boards that I’ve worked with at APIC, the steering committee, the Research Foundation, the Certification Board, have all had spectacular volunteers. We had no staff. There were just the 20 of us in this room gradually getting a little tired and ready to move on to something else. But everyone volunteered for a position and was eager and willing to do it.

The group included Grace Emori from Loma Linda and Kay Wenzel, who had an excellent program at Stanford. Kay was the author of the first infection control manual that wasn’t prepared either by the AHA or the CDC. In other words, it was very hospital process oriented. It was exactly what people needed.

So that was the meeting in 1972. There were probably 300 to 400 infection control practitioners in the U.S. and Canada. The first infection control programs and practitioners were in Great Britain.

We were confident that APIC, once it was a fully functioning organization, would be able to make a great deal of difference within a few years, that we would be able to find all of those people who’d been to Claire’s courses or other courses and get them together, get a start on everything.

The dream, and I think all of us shared this, was that every hospital within a few years would have an infection control program staffed at least part time by someone who had received some training. And we had committees addressing several of those things. There was virtually no literature about hospital infections. There were letters, generally reporting outbreaks but there was no real science. And there were 20 of us. We had no funding. We each chipped in 20 bucks for postage and things like that. There was no Internet, kids! There were no phone calls, in fact, because phone calls were very expensive, and would have used up our 20 bucks in a big hurry.

We had a committee appointed to start developing an international infection control conference within three years, and of course, none of us really had experience with this. So there you are, 20 inspired people with a very small sum of money to get this going and volunteers who were determined that this was going to happen.”
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Mental health challenges in the workplace. Burnout. Toxic leadership. At the core of each of these challenges is connection. How, as leaders, do we build positive, effective connections with others at work? It’s time to get smart on what drives disconnection and, more importantly, get skilled in fueling sincere, genuine connections. Col. DeDe Halfhill, USAF Retired, delivers a thought-provoking conversation on how the words you choose to use, and the empathy they can convey will not only save lives but deepen trust, increase resilience, and inspire courage in the organizations we lead. She will be speaking at APIC’s annual conference in Indianapolis on Monday, June 13.

Described by some as a “leadership hero and a total badass,” U.S. Air Force retired Colonel, DeDe Halfhill, is a proven leader who draws from 25 years of command experience and time spent as a senior advisor to the military’s highest-ranking officials to provide a real-world perspective on the power of embracing humanness and vulnerability in leadership.

**How are the two worlds (military and healthcare) similar, and how can these two types of professionals learn from each other regarding leadership?**

How are these two worlds similar? They both involve people! I say that in jest, which I know is hard to convey in print. Leading, regardless of the rules, regulations, adherence to standards or the weight of the mission at hand is still all about people. The truth is we’re emotional beings bringing the entirety of our lived experiences to work … some good, some not so great. Unfortunately, the “not so great” experiences tend to rear their ugly heads in the form of self-protection when we find ourselves in stressful environments like those we often encounter in the military or healthcare. It’s in these moments that we don’t always show up as our best selves. Empathy for others and self-compassion for ourselves is key. The last few years have proven challenging across industries, healthcare especially. I think the thing we need now more than ever is to know that we’re all doing our best and to support one another in doing better when we can.

What does an environment that has leadership who communicates clearly and supports wellbeing of staff look like, and what does an environment that does not have this sort of leadership look like?

I fundamentally believe there is no greater leadership competency than communication. It is the key to success of any organization, and no matter how hard we try, we can always do better. Good communication isn’t just about what we say. Good communication is really about how well we listen. Unfortunately, we’re not always as great in that arena as we could be. I think we mean well, but time, urgent tasks, and the ever growing inbox count leaves us feeling hurried, frazzled and failing to fully listen to people. Good communication means we’re slowing down enough to be present, to be focused and to hear both what is being said and what is being left unsaid. Wellbeing is a topic every industry is trying to understand and address. I’m convinced the answers are in

“I fundamentally believe there is no greater leadership competency than communication. It is the key to success of any organization, and no matter how hard we try, we can always do better.”
How do you recommend a healthcare professional develop the leadership qualities you discuss?

One of my favorite Brené Brown quotes is “Who you are is how you lead.” My experience has been that as leaders we take little time to really think about how the experiences that have shaped our lives are showing up in how we lead. So, becoming a better leader really starts with getting curious about who we are, what drives us, what has shaped us and how might those things might be affecting the way we show up with others. Coaching is a great way to explore this space, but so is the simple act of journaling. Some of my favorite leadership journaling prompts are:

- What’s present for me now?
- What’s going well? What’s creating that?
- What’s challenging?
- What needs my attention?
- What’s meaningful?
- What strengths do I notice in myself?
- What strengths and contributions do I notice in others?
- What am I learning?
- What am I committing to?

Taking the time to ask myself these questions regularly and noticing what I’m thinking and feeling while answering them has always helped identify where I have room to grow and learn. The bottom line is leadership is a practice. No one does it perfectly. You will make mistakes, a lot of them. But, we get the change to own our mistakes, be honest about them, learn from them and grow.

What advice do you have for professionals who see their leader/supervisor experiencing burnout?

I love this question, because at its core it acknowledges one very important thing … that we’re all human. Sometimes leaders think they need to be superhuman, have all the answers, do all the right things, never show weakness. But that’s not true. Everyone, regardless of position, has spent the last two years navigating new realities, balancing competing demands, and in most cases doing their best to figure out the best next step. Leading can be isolating but it doesn’t make us any less human. We all crave belonging and connection. Even leaders. :-) Sometimes a genuine “how are YOU?” could make all the difference to a leader who needs a reminder that they’re human too! 🌵

HANNAH BATTEY, MENTEE

By the end of my six-month contract, I had solidified myself as a contributing member of the IP team.

As a result of the additional workload of the pandemic, I am pleased to report that a new IP role was created in September 2021. I applied, interviewed, shared all of my infection prevention experience, and was offered a full-time IP position. In June 2021, I passed my CIC examination. Within a year and a half, I transitioned from a volunteer, intern, and IP to certified IP amidst the COVID-19 pandemic.

Sometimes I wonder how the events might have played out differently if it wasn’t for the COVID-19 pandemic. Would I have been volunteering for six months? A year? Would I have been offered a position? Surely other people with “atypical” IP backgrounds have broken down the barriers before and had success in the field…how did they do it? In the last two years, the IP profession has become more visible. I have noticed an increased discussion around expanding the pipeline and encouraging applicants from diverse backgrounds to apply. But how do we support and train this influx of new personnel? Where are the paid associate-level positions? Surely there must be a way that we can prepare the future IPs and ensure that they can pay their essential bills in the meantime. Turnover is high. IPs are leaving the field due to burnout and higher-paying alternatives. I recognize that not everyone is lucky enough to have Brenna or Annemarie cheering them on. Still, I am hopeful that the future of IP will encourage multidisciplinary teams with diverse backgrounds and experiences. If you’re reading this and considering a career as an IP or a role as an IP mentor, go for it! If you are passionate about what you want to do, it will be apparent that you will ultimately find your way and be successful. 🌵

Hannah Battey BS, MS, CIC, is an infection preventionist for City of Hope National Medical Center in Duarte, California. and Brenna Duran BS, MA, PhD, CIC, is an infection preventionist at the City of Hope and is a Prevention Strategist panel member.

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<td>BD</td>
<td><a href="http://www.bd.com">www.bd.com</a></td>
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100 years of infection control. We’ve got this.

Infection prevention across the care continuum – well-tolerated, easily accessible and high-level disinfectants, making compliance simple.

Infection Control Done Right.™
Patient safety solutions

A safe and hygienic patient area is important. The Silentia Screen System is the leading alternative to privacy curtains, offering a clean privacy solution for all patient care settings. Between patient changes or transfers, the hard and smooth surfaces allow for quick cleaning and create a safer patient environment with minimal workflow disruptions.

Learn about our commitment to infection prevention and explore our innovative privacy screen system at silentiascreen.com.