



DAILY NEWS

THE DAILY NEWSPAPER OF THE APIC 2018 ANNUAL CONFERENCE

HIGHLIGHTS ISSUE

FREE

Microbiomes: Infection Prevention of the Future?

APIC members already have a growing number of pathogens to worry about. So why should you care about the human microbiome as well?

Jonathan Eisen, PhD, University of California, Davis, listed a variety of reasons during the APIC 2018 closing plenary session to a room full of infection preventionists (IPs).

“Microbiomes are complex and vari-

able, and everywhere,” he said. “Patterns in microbiomes are correlated to many traits of interest, and thus microbiomes can serve as important diagnostic tools.”

Basically, the human microbiome is the sum-total collection of microbes found in and on people, Eisen said. As Research and Knowledge accelerates, the microbiome has become a hot topic both inside and outside the medical community.

One reason why there’s so much interest in the microbiome may be due to “post-genome blues,” Eisen said. The Human Genome project didn’t answer many key health questions, so there’s hope that the microbiome can.

It’s also becoming easier and less costly to sequence genomes of microbes, which has completely transformed lab research. In the healthcare setting, Eisen said this means a lab could read the DNA sequence

of an organism causing an infection in as little as 30 minutes. This means that culturing may not be needed.

Eisen noted that one side effect of the excitement about the microbiome has been the rise of “snake oil” ideas that modifying human microbiomes will “cure every ailment, and everyone will be happy and great.”

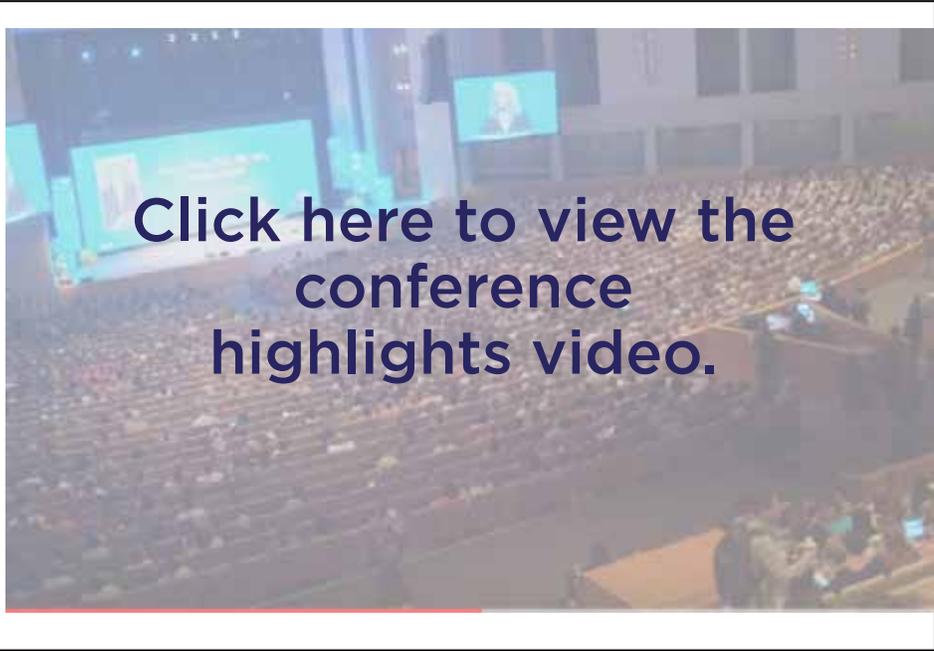
“If I had time, I could give out five ‘overselling the microbiome awards’ a day,” Eisen said. “Some of this is very, very scary stuff.” This “microbiomania” can be comparable to germaphobia, he said.

Eisen said his top five things to know about microbiomes include:

1. Microbiomes are complex and understudied. There’s a great diversity of microbes throughout the human body.
2. Microbiomes have extensive amounts of variation, akin to genomic variation within species. This variation also applies to humans.
3. Microbiomes’ complexity and variability isn’t random. Microbiomes are influenced by factors like age, diet, disease states, pregnancy, and more. And people’s personal microbiomes can influence their probability of contracting an infection after being exposed to a pathogen.
4. Microbiomes can be impacted by their environmental surroundings, including everything from cell phones to pets. “Microbiome of surroundings” research can provide insight into humans and pathogens in the environment.
5. Microbiomes can be modified both accidentally and purposefully through a variety of factors such as antibiotics, diets, hygiene, C-sections, and even the built environment.

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Film Festival Winner Demonstrates Proper Surgical Attire to Keep Patients Safe



Permanente Medical Group, Santa Rosa receives the Film Festival Grand Prize Award.

Permanente Medical Group, Santa Rosa is the winner of its eighth annual Film Festival competition, to be awarded during APIC's 45th Annual Conference. The video entitled "[KP SRO Surgical Attire](#)," emphasizes the importance of proper surgical dress.

KP SRO's black and white silent film – produced in fast motion with a dramatic

Hollywood soundtrack – takes a humorous approach to the rules of surgical attire. We see a man with a long fake beard attempting to don a mask, cover a full head of clown hair, and trim his gorilla hair. This lighthearted video entertains the viewers while also placing emphasis on surgical attire that is necessary to keep patients safe.

APIC Film Festival: People's Choice Award Winner

Conference attendees and APIC members had the opportunity to cast their vote for the APIC Film Festival's People's Choice Award. The winner was [Construction and Renovation](#), submitted by Mt. Washington Pediatric Hospital.



Erica Jones, Mt. Washington Pediatric Hospital, left, accepts the APIC Film Festival People's Choice Award from 2018 APIC President Janet Haas.

Who Cleans the "Hot Zone" Around Your Patient Beds?

Take a look at a patient room in your facility. Are you sure key components like respiratory equipment, patient monitors, feeding pumps, and bed rails are cleaned every day?

Sara Townsend, MS-HQS, CIC, Children's Hospital of Philadelphia (CHOP), said her infection prevention team's answer to that question was "no." And that insufficient response led to the creation and implementation of a multidisciplinary cleaning project called Don't YOU Clean That?

During a Friday morning session, Townsend explained how the project was developed and administered—and the glowing results.

The project began in fall 2016 and involved CHOP's staff of six infection preventionists (IPs) and two associate IP, along with the environmental services (EVS), nursing, respiratory therapy, child life, physical therapy, and family services departments.

"The important message we had to deliver is this is a safety project, and EVERYONE needs to work together to improve our patients' safety," Townsend said.

The project consisted of dividing patient rooms into zones within a patient room. There were hot zones, warm zones, parent zones, cool zones, and cold zones, based on factors like the amount of equipment nearby.

The Don't YOU Clean That project began with intensive care units (ICU) room hot zones, which included the area directly around the patient bed or crib. This encompassed controls, monitors, carts, pumps, the headwall, the patient bed, toys, and chairs.

Townsend said IPs visited patient rooms one day at 4 PM, after the end of the daily cleaning period. The IPs did adenosine triphosphate (ATP) rounds in the hot zone, aiming for an ATP threshold of less than 250 relative light units (RLUs). But the numbers were substantially higher on al-

HAI Survivor Says Now More Than Ever, Patients Need IPs to Take the Lead in Infection Control

Before 2006, Alicia Cole's only experience with hospitals was as an actress playing doctors and nurses on TV.

But that August, Cole underwent surgery for two large uterine fibroids. And that's when the trouble began, she told thousands of APIC attendees during Wednesday morning's opening plenary session.

"I'm one of the lucky ones. I survived a healthcare-associated infection," she said. And not just any infection. After her surgery, Cole was diagnosed with sepsis, *Pseudomonas*, Methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant Enterococcus (VRE), and necrotizing fasciitis infections.

Cole shared her story with attendees, and gave advice from a patient's perspective about how infection preventionists (IPs) can help protect the estimated 75,000 patients who die each year from healthcare-associated infections (HAIs).

"Here's what I want to share with you on behalf of patients: Patients want you to take the lead," she said. "You are the experts. Stand your ground. Stand up for patients, because now more than ever, patients need you."

Cole said she had fever, chills, and nau-

sea after her fibroid surgery. She was told it was a bad reaction to anesthesia, but in the next few days, she developed pain, swelling, and frequent vomiting. "The doctor kept saying, 'Don't worry, it's no big deal,'" Cole said. "But he couldn't explain what was going on." And, Cole's condition did not improve.

Due to her fluid retention, the doctor told her he would open up her incision a little to let the fluid drain. "He got a tray from the nurses' station and put it on my thighs" and did the procedure, Cole said. But the next morning there wasn't much drainage. And later, when a certified nursing assistant (CNA) did an abdominal dressing check, Cole's mother saw a black dot on Cole's stomach.

Cole said the CNA said the dot was lint or a mole. Cole's mother insisted the CNA call the doctor. "But the CNA said, 'No, I'm not going to get yelled at by this doctor for something that's nothing,'" Cole said.

So Cole's mother called the doctor, and in the hour and a half it took him to arrive, the black dot had been replaced by a pustule. "And I saw the doctor's face go white. He said this is serious, this is bad," Cole said.

The CNA didn't answer the call button,



Alicia Cole delivers the Keynote address on June 13.

so the doctor enlisted Cole's mother. "He had my mother put on gloves. Then he went to the window seat where he had put the tray from the day before," Cole said, as the audience gasped. "He took a scalpel out of his pocket," she said, as the audience gasped again, "It was in plastic." The doctor told Cole's mother to hold her flat while he opened up Cole's incision. "He stuck his fingers into my abdomen and began pulling it open," Cole remembers, while her mother did the same thing on the other side of her body.

The doctor grabbed an "open box of fluffs and began soaking up brown oozy stuff," Cole said. Meanwhile, her father was out in the hallway demanding a consultation with an infectious disease specialist.

How did he know to do that? Because earlier, "one of my nurses, who was friendly and collegial with the infectious disease nurse, came into the room, shut the door, and pulled the curtain," Cole said. "She said, 'I have to talk to you in confidence because I could lose my job.' She told my parents 'your daughter is very sick, and time is of the essence.'"

Cole said the nurse said she could make a suggestion to the doctor to call an IP, but the doctor was a bit of a cowboy and probably wouldn't listen. But if Cole or her parents asked for an infectious disease specialist, the doctor would have to refer them to one.

The next afternoon, the hospital's IP



The crowd listens intently during the Opening Plenary.

Poverty-related Diseases Rising in Unexpected Areas

When it comes to poverty-related diseases, there's good news—statistics are improving in Africa, Asia, and Latin America. However, many of those same diseases—once eradicated from the developed world—are rising there again.

“We’re making great progress, only to lose ground to modern 21st century forces, ranging from poverty to climate change to a terrible rise in anti-science in America,” according to Peter Hotez, MD, PhD.

Dr. Hotez has termed the phenomenon “Blue Marble Health,” emblematic of a sea of change. “We used to talk about developing versus developed,” Hotez said in Thursday’s plenary session, Neglected Tropical Disease and “Antipoverty” Vaccines. “All economies are rising, but leaving behind a segment of society. Most of the world’s neglected tropical diseases are in the largest 20 countries—the G20—and Nigeria. Why?

It’s the poor living among the wealthy accounting for most of it.”

Those new “global hotspots” include Eastern and Mediterranean Europe along with pockets in the United States.

“We have 19 million Americans that live in extreme poverty, earning only one-half of what is the U.S. poverty line,” Dr. Hotez said. “About 5 million people live on less than \$2 a day, the same level of poverty we’d use anywhere elsewhere.”

He has seen a hookworm epidemic in rural Alabama and Zika transmission in South Texas.

Earlier in his career, Dr. Hotez had successfully raised interest—and funds—to fight neglected tropical diseases around the world. Bringing the issue close to home surely would capture attention, he thought.

It hasn’t. “That’s been a tough message



Neglected tropical diseases are rising in more developed nations, Peter Hotez said during Thursday’s plenary session.

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Welcome Reception Kicks Off Conference!

Attendees at the Welcome Reception at the Orchestra Hall enjoyed a variety of food and beverages, music from the Mill City String Quartet, and the opportunity to reconnect with old friends and meet some new ones.



Swivettes and Other Hidden Mold Sources Can Be Endangering Vulnerable Patients

Mold is everywhere. In the ecosystem, it's important for decomposing organic matter. And in the healthcare world, it was key in the discovery of penicillin.

But over the last few decades, there has been a steady increase of mold in healthcare facilities, which can cause serious complications for vulnerable patients, said a pair of speakers during the Thursday afternoon session, Risks From Flush-Toilet Devices in ICU Settings.

Tiffany Dogan, MPH, CIC, Michigan Medicine, said along with water-intrusion events, mold reservoirs in healthcare settings include the laundry facility, construction that disrupts existing mold spores, and air handling and ventilation systems that push mold spores into patient rooms.

But one of the obscure sources is flush-toilet devices (FTDs), also known as patient-care units or swivettes. These devices encompass a toilet and sink all in one, with a dialysis hookup.

Dogan and other Michigan infection preventionists (IPs) first encountered this problem when black mold was found on the floor of a patient room in the trauma burn intensive care unit (ICU).

Dogan said burn patients are among the immunocompromised patients who are most at risk for invasive mold infections. Other vulnerable patients include neonates and those who have undergone transplant surgery, have a traumatic injury, or have had a blood and marrow transplant, or another hematologic malignancy.

"Mold infections are frequently difficult to treat and require special consultation," Dogan said. "And infections caused by fungi are associated with morbidity and mortality."

Taking all of this into account, the Michigan Medicine infection prevention team immediately made finding the source of mold in the burn trauma patient's room a priority.

The maintenance staff dismantled the FTD and found visible mold growth. They also discovered the device had porous cabinetry and a long-standing water leak.



Kristen VanderElzen discusses mold on June 14.

A culture taken from the unit revealed *Fusarium* spp mold. Dogan said later, IPs also found *mucor* and *scedosporium* types of mold.

Hospital leadership was not very engaged with this initiative in the beginning, but Dogan said the team informed them every time mold was identified. As more cases appeared, and more burn patients needed to be evacuated from mold-contaminated rooms, "eventually we got really good engagement, and the units and hospital took ownership, leading to a facility-wide initiative regarding FTDs," she said.

IPs and other hospital staff held meetings to decide what to do with the FTDs. They concluded that the devices were too expensive to replace, but it was possible to swap out the cabinetry with nonporous material. After this occurred, Dogan said there were no new cases of mold.

But the whole incident made the IPs realize they needed a "robust mold surveillance plan and a more thorough investigation into other potential mold reservoirs," she said.

Kristen VanderElzen, MPH, CIC, University of Michigan Hospitals, said the process taught IPs that there are hidden mold

sources and that leaks can be deceiving.

"Dialysis water hookups are hiding in our walls and leaking in ways we can't see," she said. And any equipment or devices with an air-conditioning component can have condenser drain pans that are never inspected. These drain pans can also be in drop ceilings, making them even more inaccessible.

The Michigan IPs also learned that water can flow across a room to a low spot under flooring and along or within a wall. Also, any indication of rotting, or a black/brown discoloration should be investigated until a source is found. Musty or moldy odors or insect infestations are often indicators of mold. "So don't ignore them," VanderElzen said.

Michigan's risk assessment includes a "mold wheel" developed by New York City and adapted for a healthcare setting. The wheel encompasses clean-up and mold-remediation efforts, personal protective equipment codes, and containment codes.

Did you miss the CDC session on HAIs? [Click here](#) for the session recap.

Stay in Your Lane: New Algorithm Helps IPs Prioritize a Variety of Scenarios and Requests

You receive a phone call from your pediatric facility's child life manager. She has planned an event with carnival games, clowns, and food for pediatric inpatients. Parents and siblings are also invited. She asks you about infection-risk exclusion criteria for patients.

What should you do? Is this situation within your job description? Should you handle it directly, consult someone else, or refer it to another person entirely?

A group of infection preventionists (IPs) from BJC Healthcare in the St. Louis area have designed a framework called "Stay in Your Lane" to answer hypothetical scenarios an IP might encounter.

During a Friday afternoon session, three BJC Healthcare IPs explained the Stay in Your Lane framework and asked audience members how they would apply the framework to specific scenarios like the ones mentioned above.

Patti Kieffer, RN, BSN, CIC, FAPIC, said the Stay in Your Lane framework is designed to help IPs use an objective approach for prioritizing topics, issues, and projects that might arise.

Kieffer and her coworkers Carole Leone, RN, MSN, CIC, FAPIC, and Rachael Snyders, MPH, BSN, RN, CIC, got the idea for the framework during the FDA's recent investigation of heater-cooler devices and their likely contamination with *Mycobacterium chimaera* during manufacturing.

At one point, Kieffer said, "Our medical director said: 'Ladies, stay in your lane'" in regard to specific aspects of the investigation. But what does "stay in your lane" actually mean when it comes to infection prevention? The BJC IPs developed a framework they hope other IPs can use for a variety of scenarios.

"Quite frankly, we made this up," Kieffer said with a laugh. "So we want to know how it works for you."

Defining the Scope

The Stay in Your Lane framework begins with the question:

- Does a request present a real/perceived infection risk to patients? If the answer is no, refer the request to someone else.



Gail Potter-Bynoe answers questions to a quiz during the "Stay in Your Lane": Should the IP Get Involved? session.

- If the answer is yes, does the issue fall into your infection prevention plan or roles and responsibilities? If no, refer it to someone else.

- If yes, the next question is "Are control measures within your scope?" If no, consult with others.

- If yes, then you would investigate and manage the issue.

Kieffer said the framework is designed to address gray areas: ambiguous scenarios and tough questions.

The framework isn't applicable to emergency situations, including The Joint Commission or Centers for Medicare & Medicaid Services visits, or situations where all hands need to be on deck.

Furthermore, it may not be effective for reporting and data requests. "If you are the only person with access to data, even if it isn't infection prevention-related, you may need to provide the data. But if it's not your data, let it go and let others take ownership of their data," Snyders said.

The framework may also not be relevant for people with dual roles or responsibilities like occupational health, budgeting, and management of personnel, and it may not be applicable to supply-chain requests.

Framework Do's and Don'ts

Snyders offered the following do's and don'ts for applying the framework:

Do:

- Evaluate whether you have the bandwidth to help with the request.
- Ask if priorities can be shifted, or tradeoffs be made.
- Show a willingness to pitch in if there are small ways you can contribute to the project.
- Be honest; give reasons for saying no.
- Practice saying "no" out loud, and eventually it will become easier.

Don't:

- Use a harsh tone.
- Use a hesitant tone or be overly polite. Strive for a steady and clear "no."
- Hold back the real reason you're saying "no."

"The framework isn't going to solve your problems or fix the culture at your facility," Snyders said. "But it does help you determine how invested you may need to be in an issue, and provides guidance on decision-making and your own commitment to an issue."



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Terrie Lee receives the Carole DeMille Achievement Award from 2018 APIC President Janet Haas.



Contestants are pumped for the competition during Battle of the IPs at APIC Live.



Attendees are all smiles at the Selfie Wall.



Marie Wilson composes a group selfie of the APIC Tweeters during the Tweet Up in the exhibit hall.



Attendees leave their mark on the Minneapolis Selfie Wall.



Laura Rose demonstrates equipment featured in "The Role of the Healthcare Environment in Transmission of Pathogens."



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APIC President Offers an Infection Control Primer

Like some other APIC members, 2018 APIC President Janet Haas, PhD, RN, CIC, FSHEA, FAPIC, fell into infection prevention serendipitously.

The intellectual challenge, the need for creative problem solving, and the opportunity to do many different things in a day, drew her into the profession and still keeps her going today.

“Each and every person in our care is someone’s loved one,” she told a auditorium full of attendees at APIC’s opening plenary session Wednesday morning. “My goal is to make the best use of my abilities to move infection prevention forward to keep patients safe. And I know that every one of you with me in this room shares that goal.”

Haas detailed how infection preventionists (IPs) can achieve this goal.

First of all, “it’s time to rally around certification,” she said. Certification is the best objective way to show your competence and dedication to those around you, including your patients.

Then, “have the confidence to take a seat at the table,” Haas said. “If you’re not at the table, you are not advocating for infection prevention that can save patients’ lives. Make the commitment right now, right here to do this. Prepare, practice, and

present it like your patients depend on it—because they do.”

Haas also urged conference attendees to form collaborative teams at their healthcare facilities and to be force multipliers. And she offered practical suggestions about how to achieve success in healthcare-associated infection (HAI) prevention.

Haas said new leadership at her facility, Lenox Hill Hospital in New York City, wanted to make an impact on HAIs. So they instituted root-cause analysis rounds for all central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI), and other HAIs every Thursday at 4 PM.

The rounds consist of unit staff, IPs, clinical leadership, hospitalists, intensivists, infectious-disease pharmacy, housekeeping, and representatives from other ad hoc departments such as dialysis and the emergency and operating rooms.

Unit staff members present a case in a “blame-free zone,” Haas said, and talk about the challenges and changes needed. Were systems in place to prevent the infection and if so, were they followed?

Haas said some things the root-analysis rounds found are that staff was often unsure of when discharge cleaning occurred, when ATP testing was instituted, and when



2018 APIC President Janet Haas

the results needed to be communicated.

Staff was also uncomfortable about leaving a “clean” patient in the room of a *Clostridium difficile* (*C. diff*) patient, so they were moving the *C. diff* patient out of the room, Haas said. “We changed the paradigm to move the clean patient rather than the *C. diff* patient,” she said. “We also got quicker test turnaround. It now takes days instead of hours.”

In addition, the root-cause analysis rounds have resulted in the creation of a *C. diff* testing algorithm, additional training for IPs to communicate with patients and families, and a committee to deal with end-of-life issues.

Haas closed her remarks with a piece of advice for conference attendees: “Pick one thing that you need to work on in your facility and find some potential solutions.”



Implementation Science Award Winner, Ayat Abuihmoud, discusses her findings with Jeff Chludzinski during the Poster Session.

Miss an issue of APIC Daily News?

Digital versions of the *APIC Daily News* onsite issues can be viewed online. Issues contain important news about APIC, session recaps, attendee interviews, onsite photos, and much more.

[Tuesday](#)
[Wednesday](#)
[Thursday](#)
[Friday](#)

Largest Exhibit Hall in APIC History!

The APIC 2018 Annual Conference was the site of the largest exhibit hall in APIC history:

- 272 companies
- 68 first-time exhibitors
- 57,300 sq. ft. of exhibit space



Stewardship, Infection Prevention Offer Natural Synergies

Antimicrobial stewardship might seem like one more unattainable task on the infection preventionist's (IPs) already full plate. But it shouldn't be seen that way.

The work of infection prevention and control (IPC), and antimicrobial stewardship naturally intersect and interestingly enough, so does the work APIC and the Society for Healthcare Epidemiology for America (SHEA). The two organizations jointly presented the session, Leveraging the Synergy of Antimicrobial Stewardship and IPC Programs on Wednesday, June 13. The session was an outgrowth of an ongoing relationship between the two organizations.

"IPs are positioned well because of our relationship with patient care units," said Janet Haas, PhD, RN, CIC, FSHEA, FAPIC, director of epidemiology at Lenox Hill Hospital. "We are trusted advisors on our clinical care teams. We're naturally partners for this."

Diagnostic stewardship and preauthorization for antibiotics are areas where IPs have "an incredible opportunity to affect," Haas said. "We're particularly on the lookout for resistant organisms."

She encouraged engaging nurses in particularly on the "frontlines" of antibiotic use. The IP also can, and should, encourage discharge management for selected patients. For instance, a patient on a 10-day course of antibiotics may be transferred



Eddie Stenehjsem discusses stewardship.

and, without communication, "the clock starts all over again, leading to overuse. We've got to partner with our patient transfer centers, our nursing care teams, and the physicians to ensure that these kinds of details are included in that transfer."

Eddie Stenehjsem, MD, MSc, medical director of Antibiotic Stewardship at Intermountain Medical Center, and research director of the Infectious Diseases TeleHealth Program, discussed the regulatory environment, which gained momentum five years ago after a Centers for Disease Control and

Prevention report "really quantified the impact of antimicrobial resistance on public health." That momentum has been slowed down after the 2016 election.

But even without regulations, hospitals are aggressively developing stewardship programs.

"We can do this anywhere," Stenehjsem said. "If a critical access hospital with 12 beds can develop a stewardship program, anyone can."

Stewardship should extend beyond all of an organization's facilities, Stenehjsem said. "We now reach small hospitals through telehealth and telemedicine. We need to start thinking about stewardship across all of our facilities."

Even then, though, that is just a drop in the bucket of antibiotic use. Stenehjsem said that 80 percent antibiotic use is in animals and agriculture. "That's not to mention that we can be on a plane to India or Africa or Europe within a day. All of these things have to be looked at together."

Leadership buy-in is vital to success of any hospital stewardship program. "We have to be persistent to get a spot at the table," Stenehjsem said. "You have to talk about it and potentially publish it. You have to learn to write a business case. To get people talking about it, you need to speak their language."



APIC Past Presidents gather for their annual luncheon.



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Cole

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visited Cole. She advised that Cole's treatment be more aggressive and called for an MRI. "The doctor kind of negated everything she said," Cole remembers. "Then the IP said, why don't we ask the patient what she wants to do? And I said, 'Isn't she the specialist? If she's saying time is of the essence, we need to do what she's saying, like, yesterday.'"

Meanwhile, another nurse walked up to Cole's dad and shoved some papers in his pocket. "She said this is what your daughter has, but don't read this in this hospital; don't talk to me about it." Cole believes had it not been for her nurses, she might have never found out what was wrong with her.

Cole had to have six surgeries to stop the flesh-eating disease in her abdomen. "I can't tell you what it feels like to be eaten alive, to watch your body rot," she said. At one point, the doctors thought they were going to have to amputate her leg. "And the hole in my left butt cheek was so deep they wanted to put in a breast implant and cover it," she said.

Tropical Diseases

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to get across. We've had great success in raising awareness about diseases of the poor in Africa, Asia, and Latin America. Quite the opposite has happened here. What am I doing wrong in messaging that I can't get people to care about people living in America with a neglected tropical disease?"

He had learned the power of the right message previously, raising interest in eradicating those diseases as part of the United Nations-led Millennium Development Goals (The Millennium Development program sunsetted in 2015). "We wanted to change the world and get people to care about neglected tropical diseases. We didn't have access to Brangelina or Bono. That wasn't in the cards. We had to do it ourselves."

He successfully secured funds and managed a program that would deliver medications to those hard-hit areas. The results were impressive, with most of the diseases seeing a one-third to one-half reduction in

"Patient safety is no accident. It is strategic and it's deliberate. From a patient perspective, there are no silos—we see everything as one team and we see infection prevention in everything."

– Alicia Cole

When she was finally released from the intensive care unit a month later, Cole had an open, draining abdomen for three years that had to be packed twice a day. She visited UCLA's hyperbaric oxygen chamber every day for five months for drainage. The doctors also removed some of her lymph nodes, so some mornings she would have huge swellings in her face.

"It was very, very devastating. Especially for an actress," Cole said.

From her hospital bed, Cole began sharing her experience on social media, and in 2008, she and her parents founded the Alliance for Safety Awareness for Patients group.

Since then, Cole has co-sponsored two successful bills in California mandating

cases over the last 10 years. Some were eliminated as a public health problem.

Then, things changed. "Just as we're high-fiving each other on our successes, we're up against a new set of obstacles," Dr. Hotez said. "We have new global leadership, a new U.S. president, a new World Health Organization director general, a new United Nations general secretary."

Changing leadership came at a time when regional conflicts were rampant. In 2014, the Ebola outbreak came out of portions of Africa where the health system had collapsed during conflict. In Syria and parts of the Middle East, diseases like measles and polio are rising, along with some animal-related diseases.

The prevalence of those diseases in the war-torn areas are not fully known "because it's too dangerous to be in the war zones. We tend to get glimpses of this from refugees spilling over into the borders."

The economic collapse in Venezuela has led to a rise in measles—after the country had been at the forefront of eliminating the disease in Latin America two decades prior.

public reporting of HAIs and establishing training programs for hospital infection prevention. She's also a member of the Presidential Advisory Council on Combating Antibiotic-Resistant Bacteria.

"Patient safety is no accident. It is strategic and it's deliberate," she said. "From a patient perspective, there are no silos—we see everything as one team and we see infection prevention in everything," from the IV pole with fluid splatters from a previous patient, to dirty bed linen.

Cole suggested four simple measures IPs can take without risk of losing their jobs:

1. Ask to join the facility construction and interior design planning committee.
2. Leave your old infection prevention magazines in the nurses' lounge.
3. Have a "pizza and prevention party" with the environmental services staff.
4. Meet with the wound-care team.

"On behalf of patients, we've got your back as you take the lead for us," Cole concluded as the inspired audience rose in a standing ovation. "I thank you for the work you do."

Another factor influencing the rise of disease may be related to climate change, though it isn't clear, given that those areas are also in an economic downturn and have an influx of migrants. Whatever the cause, malaria is rising in Greece and Italy. Schistosomiasis is increasing in Corsica, while dengue fever is up in Portugal. Spain, Italy, and France are seeing increases in West Nile virus and chikungunya virus.

Measles in particular is showing up in the U.S. and parts of Europe, partially influenced by the anti-vaccination movement. He cited a 1998 paper in *Lancet* which linked the measles, mumps, and rubella (MMR) vaccine with autism. "Ultimately the paper was uncovered to be an elaborate fraud. The problem was it took 12 years for that paper to get retracted."

Dr. Hotez is particularly passionate about the issue, as a vaccine scientist and father of a child with autism. "There are hotspot areas in the country where large number of kindergarteners are not getting vaccinated. We're trying to understand the demographics."



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It's Time to Start Thinking about Passing the Baton to New Workers

It doesn't take much more than a glance around to see new blood is needed in the infection prevention and control (IPC) field.

APIC's *MegaSurvey* in 2015 put numbers behind it: about 41 percent of infection preventionists (IPs) are over the age of 45. At APIC 2018, Peg Pettis, RN, MPA, CIC, infection prevention manager at Rochester General Hospital, pointed out just why that was important. Retirements will be coming—and quickly. But are the replacements there?

“Some of you may think, ‘Post the job and they’ll be lined up outside my door,’” Pettis said. She pointed to an unemployment rate that is at the lowest in nearly two decades. Add in a nursing shortage—a profession that APIC's *MegaSurvey* showed was dominant in IPC—where 1 million vacancies are expected by 2022, according to the Bureau of Labor Statistics.

“You have to start thinking outside the box about where your next IP is coming from,” Pettis said. “Today's IPs aren't just

nurses. They're microbiologists, advanced practice practitioners, epidemiologists, and pharmacists.”

And more likely, they are millennials, those born between 1981 and 1997. They make up the largest sector of the workplace—and about three in four workers will be millennials by 2022.

Some of what the profession offers aligns well with what this new generation seeks. Millennials are socially conscious. Pettis cited *Harvard Business Review*, which identified young workers as socially conscious as those in the 1960s. “They don't want a job for a paycheck. They want a job where the company culture aligns with their values.”

That means that they are selective about where they work. “Instead of us asking, ‘Why should we hire you?’ They're asking, ‘Why should I want to work here?’”

But getting in the door is just the beginning. Research has shown that employees who were welcomed into a new job with a structured onboarding program were more

likely to stay with the job for three years.

“I know many of us haven't started a new job in a while. It's a little scary and kind of stressful,” Pettis said. “You can take a few steps to welcome the new IP and help decrease those stress levels.”

It means sending an email thank you when they accept the position. A week before they start, send their schedule, tell them where to meet, what time to be in the office, and the dress code. Set up the phone and computer so that everything is ready when they arrive. The day before, send a text that tells them how excited you are about seeing them.

Pettis' IPC team takes it a step further. “We always put up a welcome sign. Have bagels or a lunch. It is a long-standing tradition in our IPC department to have a welcome basket. We don't put a lot of money into it. We just stick a few things in there to help ease the transition. Cookies, candy. There's always a Tide stick in it.”

After they've learned the names of their colleagues and a few other crucial things, it is time to help them grow in the profession. “The nice thing about infection prevention is there is a multitude of products and resources out there when you are training a new IP,” Pettis said. Journals, webinars, local APIC chapter events, and national conferences can help. The Centers for Disease Control and Prevention (CDC) website includes online training videos.

APIC's *Roadmap for the Novice Infection Preventionist* is a good starting point, Pettis said. She has localized the roadmap for her institution. For instance, before they meet with a leader in a department, they may need to review a CDC video or read something published by APIC. “I can't stress enough to the new IP, you have to meet these people and develop a relationship before the poop hits the fan.”



Dr. Mary Lou Manning, the 2018 Distinguished Scientist Award recipient, advocates for the role of the infection preventionist in antimicrobial stewardship. “We're getting more in tune to this topic, but we're not sure where we belong yet. It's up to us to figure that out, not somebody else.”

Did you miss the session on MPH graduates? [Click here](#) for the session recap.

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Attendee Q & A**What's One Thing from the Conference You Will Take Back To Your Facility?**

“The TAP strategy to reduce CDI and CLABSI in acute-care hospitals.”

*Ahmed Hassaballa, MBBCH, CIC
Chicago Department of Public Health
Chicago, Illinois*

“If I had to choose one thing, I would say the importance of the environment and the fact that there are so many porous surfaces we're really unaware of. We really need to think twice about how we're cleaning. We need to use spot checks with environmental sampling to validate our cleaning.”

*Enid LeBlanc, RN, BSN, MBA
Tenet Healthcare
El Paso, Texas*



“I've been to several APIC conferences, and I always come away realizing there's a lot more work to do than I thought I had to do. I've done this for 10 years and I think I'm pretty knowledgeable, but it's good to sit in on talks where I learn something new.”

*Krist Pottorff, RN, MPH, CIC
Captain James A. Lovell Federal Health Care Center
North Chicago, Illinois*

“This is my first APIC conference, and I was impressed at the super sharing and the super ideas. It's the best infection prevention conference I have been to, and I'm going to tell my colleagues.”

*Tarek Elgodban, MD
First Medical Respond
Pearland, Texas*

**Exhibitor News**

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Continuous High-Level Disinfection in Healthcare for Reduction of HAI's

Activtek Health Solutions unveiled long-awaited Infection Prevention measures at this year's APIC conference. Award-winning ActivePure Technology's significant microbe and odor reduction greatly reduces infection and cross-contamination rates while promoting LEED Certification points for a clean and healthy environment 24/7.

Recently inducted into the Space Technology Hall of Fame, ActivePure's proven micro-biocidal and sporicidal activity treats the entire facility without chemicals or toxic by-products, leaving no residue behind. It's proprietary combination of technologies includes an accelerated dry Hydrogen Peroxide which utilizes the HVAC's air current as a catalyst to reach airborne and surface contaminants where they first begin – pathogens are not required to pass through a unit for treatment. ActivePure penetrates and immediately explodes the shell of Epidemiologically Important Pathogens on contact (up to 99.98%), including MRSA, Staph, Influenza, VOCs, molds, etc.

As members of the U.S. Green Bldg. Council, owner Beth Krah and her team focus on Upstream Healthcare and patient safety as they work closely with Architects, Infection Control Professionals and Environmental Engineers to design custom cost-conscience solutions for each facility. Ongoing strategic partnerships with top healthcare leaders ensure higher levels of patient-centered care as the industry focuses on more preventative measures and providing healthier environments for their communities.

Click [here](#) for more information.

Did you miss the session on *Candida auris*? Click here for the session recap.

Microbiomes

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Eisen followed with the top five reasons APIC members should care about microbiomes.

1. Microbiomes likely can improve the ability to prevent infection and transmission. Manipulating the microbiome may allow IPs to estimate risk of infection and reduce its probability.

2. Microbiomes should be a consideration when treating patients, especially those exposed to antibiotics or who have been hospitalized for a long time.

3. Microbiomes can potentially be used as an epidemiological and forensic tool. For instance, there's now the capability to use skin bacteria for forensic identification. And there's the ability to understand how microbes respond to cleaning practices, and how they move between people and even hospital rooms.

4. Microbiomes play a key role in the side effects associated with important activities. The microbiome in a built environ-



Jonathan Eisen discusses microbiomes during the Closing Plenary session.

ment can affect the individual microbiomes in people within that environment. But killing microbes in those environments can be detrimental to people in other ways—similar to what occurs with antibiotic overuse.

5. Microbiomes are an important tool for engaging the public in thinking about microbes and microbiology. Eisen said there are a variety of citizen microbiome

projects, include studying the microbiomes of cats, seagrass, phones, and shoes. There are even microbiome board games to get people thinking about their microbiomes.

“Microbes aren't good or bad—they can have beneficial and detrimental effects,” Eisen said. “The more we can get people to think about the diversity of microbiomes, I think the better off we are going to be.”



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Exhibitor News

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'1-2 Punch' Knocks out Pathogens in the Healthcare Environment

Effective cleaning and disinfection can decrease environmental contamination, reducing the risk of infection. Yet, hospital environments are complex, which can often result in cleaning that is inadequate. To offset these challenges, Diversey recommends a "1-2 PUNCH" program which incorporates both manual cleaning and UV-C disinfection. MoonBeam3 UV-C technology deployment can enhance the effectiveness of environmental disinfection. Today, this is recommended in hospital settings where healthcare-associated infections are of major concern, and in higher risk areas. Recent data demonstrates that every patient may benefit from this the added assurance of this technology.

"First Punch" - Manually Clean and Disinfect with Oxivir® Wipes – Diversey can help you deploy the right products and practices to help you clean and disinfect more effectively. Fast, Effective, Responsible and Sustainable, Oxivir Wipes, powered by Accelerated Hydrogen Peroxide® (AHP®*) technology improve cleaning and disinfection turnover time and reduce risk to staff, visitors, and patients, while keeping costs in line. Oxivir wipes are effective against a broad spectrum of pathogens, in just one minute. They also stay wet for the required label contact time, ensuring that disinfection is taking place while streamlining your process. With one pass, Oxivir wipes clean and disinfect surfaces and equipment, yet are gentle on people and assets. Oxivir Wipes fall into the lowest hazard category, requiring no safety warnings or personal protective equipment. Oxivir wipes are available in a variety of formats and sizes.

"Knockout" Apply MoonBeam™3 technology to add assurance that even the most difficult pathogens are down for the count - Fast, Effective, Portable and Affordable, MoonBeam3 is an ultraviolet-C disinfection device that provides a better angle for disinfection. This portable, yet powerful, solution disinfects quickly, reliably and responsibly. MoonBeam3 is cost-effective and designed for fast and

effective disinfection of patient care areas. The system offers three individually-adjustable arms that can be positioned at multiple angles to optimize the energy dose, disinfecting surfaces and non-critical equipment, in as little as 3 minutes.

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Exhibitor News

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Reach your antimicrobial stewardship goals with electronic surveillance

Antimicrobial resistance is a serious public health concern. According to the CDC, at least 2 million illnesses are caused by antibiotic-resistance each year. One way to help combat resistance is to focus on antimicrobial stewardship. But how do you know if your interventions are working?

RL's antimicrobial stewardship software helps healthcare organizations ensure the right drugs are reaching the right patients – at the right time and for the right duration.

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zation and get personalized alerts for prescriptions of restricted drugs and drug-bug mismatches. Plus, create antibiograms in seconds, monitor resistant patterns for MDROs and create customized reports to share information on-demand or via automated reports.

Interested in learning more about how RL's antimicrobial stewardship software can support your work? Visit <http://www.rlsolutions.com/rl-products> for more information on RL6 software.

Setting a New Standard for Non-Antimicrobial Soap Performance

Healthy skin is cleaner skin. PURELL Healthcare HEALTHY SOAP® with CLEAN RELEASE™ Technology sets a new standard for soap performance. This remarkably mild healthcare formulation is gentle on skin, contains no antimicrobial active ingredients or harsh preservatives, and removes more than 99% of soil and germs.^{1,2}

GOJO scientists teamed with a leading dermatologist to identify the most common causes of severe skin irritation — harsh preservatives and antimicrobial ingredients — and developed this unique hand soap formula free of them. Formulated for dry and sensitive skin, hypoallergenic CLEAN

RELEASE™ Technology soap is free of these ingredients, so it's better for skin.

In addition, CLEAN RELEASE™ Technology boosts soap performance. Its novel surfactant system reaches deeper into skin's cracks and crevices to gently remove more soil and germs than regular soap.^{1,3}

1. Augustine Scientific, Newbury OH, Ex Vivo Soil Removal Analysis, August 5, 2017

2. BioScience Laboratories, Inc.; Bozeman, MT, Study# 170398-101, Evaluation of In-Vivo Germ Removal, July 5, 2017

3. BioScience Laboratories, Inc. Bozeman, MT, Study# 1707304-101, Evaluation of In-Vivo Germ Removal, August 22, 2017

UI Medical Introduces QuickChange Wrap

UI Medical has revolutionized the incontinence market by creating the QuickChange Absorbent Wrap; the newest option for male incontinence that is lowering CAUTI rates and virtually eliminating incontinence associated dermatitis. The QuickChange Wrap is wrapped around the shaft of the penis to create a fan shape with an open top that rests against a patient's stomach. The inner lining of the wrap contains gel beading that wicks away urine when the patient voids and then dries within minutes after it is absorbed. By keeping the urine contained within the wrap and away from the patient's skin, dermatitis is

eliminated. By not having any part of the product pressed against the tip of the penis or inserted into the urethra, the UTI risk versus a condom or Foley catheter are astronomically lower.

The QuickChange Wrap is latex free and is very comfortable when applied to a patient. Each wrap can hold up to 500cc of urine, and since the urine is trapped within the gel shortly after voiding, urine will not leak onto sheets, patients, or caregivers. Its simple design and application lets a single caregiver change a patient without assistance.

Visit uimed.com for more information.

Hospital ICPs Doubt Laundered Mops and Cleaning Cloths are Risk-Free

A recent survey conducted by Contec, Inc., found that a majority of infection control practitioners (ICPs) do not trust their hospital's laundering system. Of respondents, 72 percent would not wipe their mug or drinking glass with a freshly laundered hospital mopping pad or wipe. In fact, 42 percent have noted trash, debris or hair in freshly cleaned textiles. The poll was conducted at the APIC Conference.

“The feedback from these ICPs is alarming and underscores the broken laundering process that exists in healthcare,” said Jack McBride, CEO at Contec. “Pathogens are surviving hospital laundering processes, placing patients (and hospital visitors) at risk for dangerous healthcare associated infections (HAIs). It is time for everyone involved in infection control to review their current laundering methods and take steps to reduce this risk.”

According to the survey, lack of awareness among hospital management may be contributing to this risk. 62 percent of ICPs said they have not seen their hospital senior leadership conduct a visual audit of their facility's laundry process from start to finish, nor have they seen personnel test the compatibility of their disinfectant and laundered microfiber (60 percent). More than half of respondents (54 percent) are not familiar with, or are unsure of, the Healthcare Laundry Accreditation Council and their standards for laundry inspection and “load” processes.

Research by Contec presented at the conference and published in the American Journal of Infection Control, Effectiveness and Bioburden of Microfiber Mops Used to Clean Healthcare Environmental Surfaces, reveals 50 percent of laundered mops and wipes still contain unsterile, living bacteria levels that exceed national standards. Microscopic images of microfiber flat mops were scanned before and after laundering. Dirt and debris was discovered entrapped in laundered microfibers. Moreover, residual dirt in laundered mops has been shown to neutralize disinfectants, and laundry processes of mops and wipes can diminish quality, enabling cross-contamination.

By contrast, disposable microfiber cleaning products offer a superior clean, optimize the power of disinfectants and eliminate the risk of cross-contamination posed by relaundered products. To learn more about the broken laundering process in healthcare, view these [confessions](#) and check out solutions at [Contec Professional](#).

Thank you for joining us.

**Can't wait to see you
next year!**



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Photo courtesy of Philadelphia Convention and Visitors Bureau.

Clean

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most every reading.

Then the IPs did a survey of almost 400 EVS and nursing department staff, asking which department was responsible for cleaning each piece of equipment.

The survey results showed that the nursing staff didn't "officially" clean anything. EVS cleaned the patient room and only select equipment on which they had training. Respiratory therapy wiped down ventilators in the ICUS. Child life cleaned toys after use, and physical therapy cleaned equipment like wheelchairs after use.

"Most people assumed EVS cleaned everything in the room," Townsend said. "EVS thought other teams knew how to clean."

Townsend said the survey also unearthed the following concerns:

- Some nursing staff felt uncomfortable with other disciplines wiping pumps or respiratory equipment.
- EVS staff felt like cleaning equipment they weren't familiar with could cause harm to the patient.
- Administration staff thought the user of the equipment should clean it.

Taking all of this into account, in January 2017, the Don't YOU Clean That project team came up with the following daily cleaning schedule recommendations:

- EVS cleans bed/cribs and other nearby equipment like bedside tables.
- The respiratory team cleans respiratory equipment.
- The nursing team cleans pumps and monitors that are connected and unconnected to patients.

The team also came up with two hot-



Attendees listen to Sara Townsend present during "Don't YOU Clean That?"

zone implementation-plan goals:

- Training: The survey data found there was a 40 percent understanding of who cleans what in the hot zone. The team made a goal of 90 percent.

- Cleanliness: The baseline showed that fewer than 40 percent of targeted points achieved ATP thresholds of less than 250 RLU. The team set a goal of 80 percent.

Implementation of the plan included creating core cleaning teams overseen by unit champions from nursing, EVS, and respiratory therapy. These teams did a Hot Zone Road Zone, presenting the project to key stakeholders and hospital administration.

Initial findings of the first phase of the implementation plan included:

- Teams needed more information about the disinfectant, like how long it takes to dry.
- EDS workers were scared to clean the bed because of all the attachments, but nursing was happy to help.
- Teams needed better education materials and visual aids.
- Teams needed to have non-paper rounding tools.
- Teams discovered that huddling twice a day made a difference.
- Unit champions needed to understand what was expected of them.
- Collecting ATP data was more complicated than IPs thought.

For the house-wide rollout in inpatient units, Townsend and the team corrected these issues, including making a hot zone tool kit that featured a project visualization tool that's color-coded by department.

Townsend said post-implementation survey result show:

- 83 percent of the departments now know who cleans what in the hot zone. "Our goal was 90 percent and although we haven't reached that yet, this is a 107 percent improvement from where we started," she said.
- ATP data of five surfaces swabbed in the hot zone came in just under 80 percent, which is an 82.5 percent increase from baseline.

Miss a Session?

Did you miss any of these sessions? Click on the title to read the recap in *APIC Daily News*.

- [1302 - Infection Prevention Practices on the Healthcare Frontier: Emerging Models of Ambulatory Care](#)
- [1502 - Changing Landscape of IPC in Nursing Homes](#)
- [2205 - Influenza in Long Term Care: Stop the Spread](#)
- [2101 - Mapping Your Way to Success: Program Evaluation for the Infection Preventionist](#)