ICNC Member's Portal Archives

ICNC Position Paper on C-Difficile by Anita Mancussi, RN, BSN

ICNC Position Paper

Clostridium Difficile Associated Disease in Extended Care Facilities

In fulfilling the mission statement of the Infection Control Nurses of Connecticut (ICNC), the organization has developed the following position paper on the care of residents in extended care facilities (ECFs) experiencing clostridium difficile (C. difficile) disease. Included are suggestions for the overall infection control practices to maintain the health and welfare of residents as well as staff and visitors. The position paper is presented as a guideline only.

< To Review Click/Tap on the Graphic at Left

http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/cdiffpositionpaperfinalversion3.pdf

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^ Click/Tap Above Graphic - For Bedbugs in LTC PowerPoint Presentation

Bedbug (Cimex Lectularis) Prevention and Response Policy and Procedure

Purpose: To prevent the possibility of bedbugs being brought in with resident belongings and to describe processes and procedures to manage residents should a bedbug infestation occur. *Read More Click/Tap Here*

http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/icnc-bedbugsltcf-fnl.pptx

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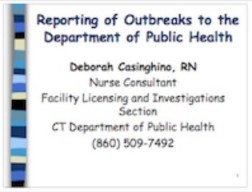
PowerPoint Presentations form the Recent ICNC Spring Annual Meeting 2014

Click/Tap on Each Graphic to Download Source Material



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http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/icnc-occupationalhealth-drnash.pdf

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ICNC- New Haven Chapter Meeting Notes (06/20/14)

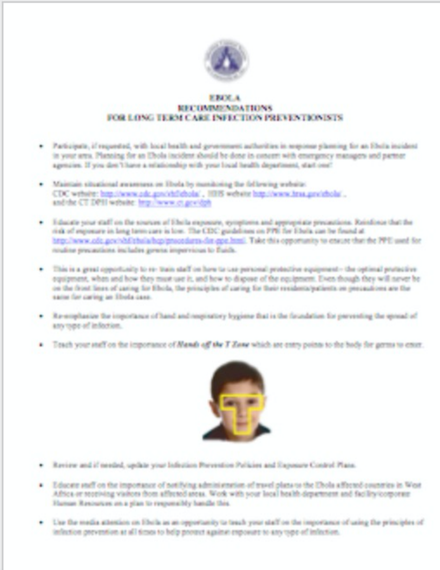
The meeting was called to order at 12:20 PM with the following members in attendance: Barbara O'Grodnick, Chris Orris, Karlene Brown, Judy Wrenn, Linda Hjort, Raeann Paparello, Ann O'Dea, Sue Dubb and 3 new members: Melody Solano, Beth Samuels and Kim Gray.

Sue opened the meeting with introductions of those at the meeting. She then proceeded to provide the group with an update on infectious disease that she had recently received while attending the June Quarterly CAPHN meeting.

MER CoV Update: 3 cases to date in the US. All were HCWs with a history of working with MER CoV patients in Saudi Arabia. All 3 have recovered without... (Read full report, click/tap on graphic.)

No Link

2014



EBOLA
RECOMMENDATIONS
FOR LONG TERM CARE INFECTION PREVENTIONISTS

ICNC Recommendations - Ebola

Governor Dannel P. Malloy

GOVERNOR DANNEL P. MALLOY

GOV. MALLOY OUTLINES STATE'S POLICIES FOR MONITORING TRAVELERS FROM GUINEA, LIBERIA, AND SIERRA LEONE

CT Travel Policies - Ebola

http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/icnc-recommendations.pdf

http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/govmalloyoutlinesstatepoliciesmonitoringtravel.pdf

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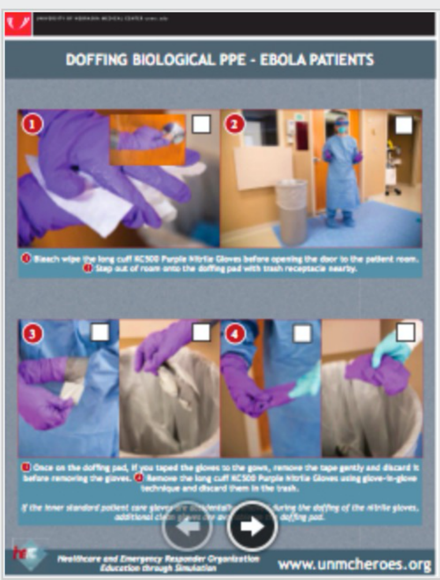

Doffing Biological PPE - Ebola Patients

Doffing Biological PPE - Ebola Patients Continued

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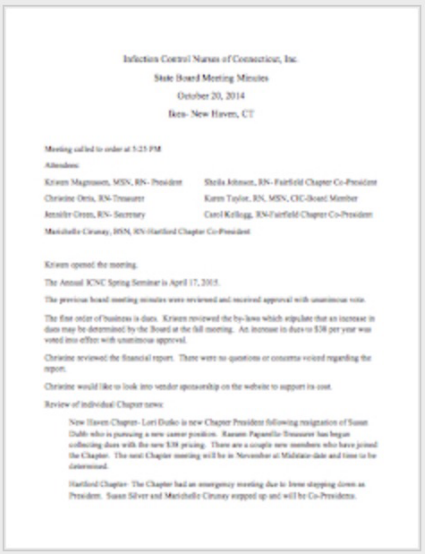


Infection Control Nurses of Connecticut, Inc.
State Board Meeting Minutes
October 20, 2014
Ikes- New Haven, CT

Meeting called to order at 5:23 PM
Attendees:

Kristen Magnussen, MSN, RN- President — Sheila Johnson, RN- Fairfield Chapter Co-President
Christine Orris, RN-Treasurer — Karen Taylor, RN, MSN, CIC-Board Member
Jennifer Green, RN- Secretary — Carol Kellogg, RN-Fairfield Chapter Co-President
Maricbelle Ciruway, BSN, RN-Hartford Chapter Co-President

Kristen opened the meeting.

The Annual ICNC Spring Seminar is April 17, 2015.

The previous board meeting minutes were reviewed and received approval with unanimous vote.

The first order of business is dues. Kristen reviewed the by-laws which stipulate that an increase in dues may be determined by the Board at the fall meeting. An increase in dues to $38 per year was voted into effect with unanimous approval.

Christine reviewed the financial report. There were no questions or concerns voiced regarding the report.

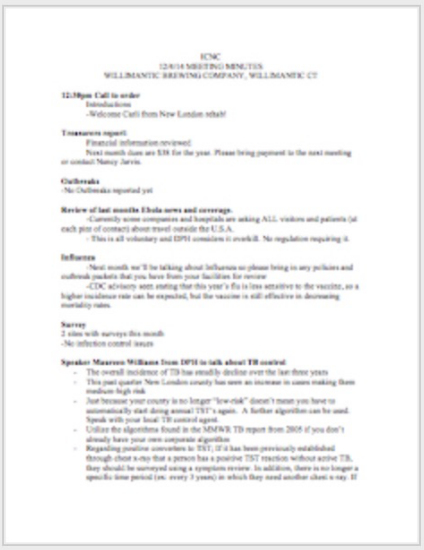
Christine would like to look into vendor sponsorship on the website to support its cost.

Review of individual Chapter news:

New Haven Chapter- Lori Dalko is new Chapter President following resignation of Susan Dubb who is pursuing a new career position. Rasann Papanello-Treasurer has begun collecting dues with the new $38 pricing. There are a couple new members who have joined the Chapter. The next Chapter meeting will be in November at Midstate date and time to be determined.

Hartford Chapter- The Chapter had an emergency meeting due to Irene stepping down as President. Susan Silver and Maricbelle Ciruway stepped up and will be Co-Presidents.

ICNC-Minutes October 2014



ICNC
12/8/14 MEETING MINUTES
WILLIMANTIC BREWING COMPANY, WILLIMANTIC CT

12:30pm Call to order
Introductions
-Welcome Carli from New London rehab!

Treasurers report:
Financial information reviewed.
Next month dues are $38 for the year. Please bring payment to the next meeting or contact Nancy Jarvis.

Outbreaks
-No Outbreaks reported yet

Review of last months Ebola news and coverage.
-Currently some companies and hospitals are asking ALL visitors and patients (at each pint of contact) about travel outside the U.S.A.
- This is all voluntary and DPH considers it overkill. No regulation requiring it.

Influenza
-Next month we'll be talking about Influenza so please bring in any policies and outbreak packets that you have from your facilities for review
-CDC advisory sent stating that this year's flu is less sensitive to the vaccine, so a higher incidence rate can be expected, but the vaccine is still effective in decreasing mortality rates.

Survey
2 sites with surveys this month
-No infection control issues

Speaker Maureen Williams from DPH to talk about TB control:
- The overall incidence of TB has steadily decline over the last three years
- This past quarter New London county has seen an increase in cases making them medium-high risk
- Just because your county is no longer "low-risk" doesn't mean you have to automatically start doing annual TST's again. A further algorithm can be used. Speak with your local TB control agent.
- Utilize the algorithms found in the MMWR TB report from 2005 if you don't already have your own corporate algorithm
- Regarding positive converters to TST, if it has been previously established through chest x-ray that a person has a positive TST reaction without active TB, they should be surveyed using a symptom review. In addition, there is no longer a specific time period (ex: every 3 years) in which they need another chest x-ray. If

ICNC-Eastern Mins. Dec 2014

http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/icnc-minutes-oct2014.pdf

http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/icnc-eastern-dec2014.pdf

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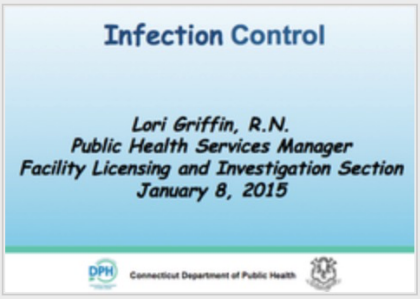
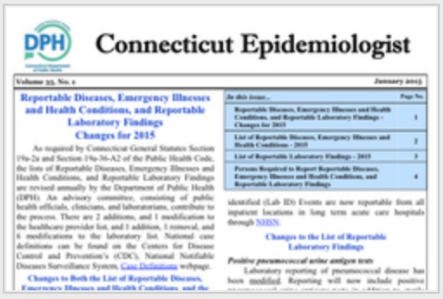
2015



Facility Licensing & Investigation - PowerPoint



Reportable Diseases

http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/ppoutbreakhrtfrdchptrjan2015.pdf

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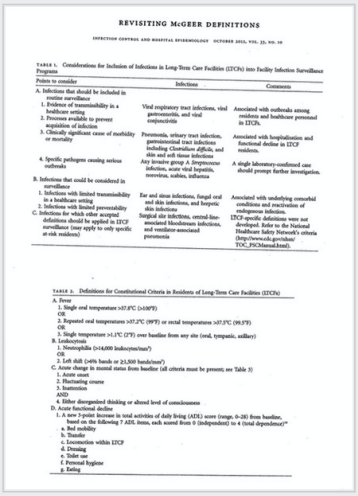
reportablediseases.pdf



REVISITING McGEER DEFINITIONS

INFECTION CONTROL AND HOSPITAL EPIDEMIOLOGY OCTOBER 2012, VOL. 33, NO. 10

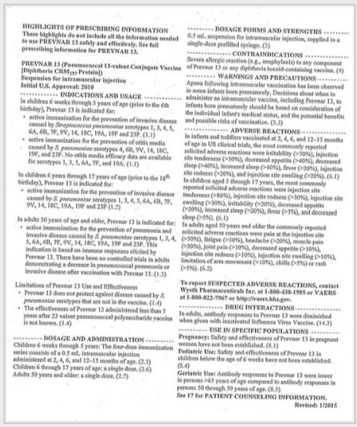
TABLE 1. Considerations for Inclusion of Infections in Long-Term Care Facilities (LTCFs) into Facility Infection Surveillance Programs

Points to consider	Infections	Comments
A. Infections that should be included in routine surveillance		
1. Evidence of transmissibility in a healthcare setting	Viral respiratory tract infections, viral gastroenteritis, and viral conjunctivitis	Associated with outbreaks among residents and healthcare personnel in LTCFs.
2. Processes available to prevent acquisition of infection		
3. Clinically significant cause of morbidity or mortality	Pneumonia, urinary tract infection, gastrointestinal tract infections including Clostridium difficile, and skin and soft tissue infections	Associated with hospitalization and functional decline in LTCF residents.
4. Specific pathogens causing serious outbreaks	Any invasive group A Streptococcus infection, acute viral hepatitis, norovirus, scabies, influenza	A single laboratory-confirmed case should prompt further investigation.
B. Infections that could be considered in surveillance		
1. Infections with limited transmissibility in a healthcare setting	Ear and sinus infections, fungal oral and skin infections, and herpetic skin infections	Associated with underlying comorbid conditions and reactivation of endogenous infections
2. Infections with limited preventability	Surgical site infections, central-line–associated bloodstream infections, and ventilator-associated pneumonia	LTCF-specific definitions were not developed. Refer to the National Healthcare Safety Network's criteria (http://www.cdc.gov/nhsn/TOC_PSCManual.html).
C. Infections for which other accepted definitions should be applied in LTCF surveillance (may apply to only specific at-risk residents)		

TABLE 2. Definitions for Constitutional Criteria in Residents of Long-Term Care Facilities (LTCFs)

A. Fever
1. Single oral temperature >37.8°C (>100°F)
OR
2. Repeated oral temperature >37.2°C (99°F) or rectal temperature >37.5°C (99.5°F)
OR
3. Single temperature >1.1°C (2°F) over baseline from any site (oral, tympanic, axillary)
B. Leukocytosis
1. Neutrophilia (>14,000 leukocytes/mm³)
OR
2. Left shift (>6% bands or ≥1,500 bands/mm³)
C. Acute change in mental status from baseline (all criteria must be present; see Table 3)
1. Acute onset
2. Fluctuating course
3. Inattention
AND
4. Either disorganized thinking or altered level of consciousness
D. Acute functional decline
1. A new 3-point increase in total activities of daily living (ADL) score (range, 0–28) from baseline, based on the following 7 ADL items, each scored from 0 (independent) to 4 (total dependency)**
a. Bed mobility
b. Transfer
c. Locomotion within LTCF
d. Dressing
e. Toilet use
f. Personal hygiene
g. Eating

Revisting McGeer Definitions



HIGHLIGHTS OF PRESCRIBING INFORMATION
These highlights do not include all the information needed to use PREVNAR 13 safely and effectively. See full prescribing information for PREVNAR 13.

PREVNAR 13 (Pneumococcal 13-valent Conjugate Vaccine [Diphtheria CRM_{197} Protein])
Suspension for intramuscular injection
Initial U.S. Approval: 2010

INDICATIONS AND USAGE
In children 6 weeks through 5 years of age (prior to the 6th birthday), Prevnar 13 is indicated for:
- active immunization for the prevention of invasive disease caused by *Streptococcus pneumoniae* serotypes 1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F and 23F. (1.1)
- active immunization for the prevention of otitis media caused by *S. pneumoniae* serotypes 4, 6B, 9V, 14, 18C, 19F, and 23F. No otitis media efficacy data are available for serotypes 1, 3, 5, 6A, 7F, and 19A. (1.1)

In children 6 years through 17 years of age (prior to the 18th birthday), Prevnar 13 is indicated for:
- active immunization for the prevention of invasive disease caused by *S. pneumoniae* serotypes 1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F and 23F. (1.2)

In adults 50 years of age and older, Prevnar 13 is indicated for:
- active immunization for the prevention of pneumonia and invasive disease caused by *S. pneumoniae* serotypes 1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F and 23F. This indication is based on immune responses elicited by Prevnar 13. There have been no controlled trials in adults demonstrating a decrease in pneumococcal pneumonia or invasive disease after vaccination with Prevnar 13. (1.3)

Limitations of Prevnar 13 Use and Effectiveness
- Prevnar 13 does not protect against disease caused by *S. pneumoniae* serotypes that are not in the vaccine. (1.4)
- The effectiveness of Prevnar 13 administered less than 5 years after 23 valent pneumococcal polysaccharide vaccine is not known. (1.4)

DOSAGE AND ADMINISTRATION
Children 6 weeks through 5 years: The four-dose immunization series consists of a 0.5 mL intramuscular injection administered at 2, 4, 6, and 12–15 months of age. (2.3)
Children 6 through 17 years of age: a single dose. (2.6)
Adults 50 years and older: a single dose. (2.7)

DOSAGE FORMS AND STRENGTHS
0.5 mL suspension for intramuscular injection, supplied in a single-dose prefilled syringe. (3)

CONTRAINDICATIONS
Severe allergic reaction (e.g., anaphylaxis) to any component of Prevnar 13 or any diphtheria toxoid-containing vaccine. (4)

WARNINGS AND PRECAUTIONS
Apnea following intramuscular vaccination has been observed in some infants born prematurely. Decisions about when to administer an intramuscular vaccine, including Prevnar 13, to infants born prematurely should be based on consideration of the individual infant's medical status, and the potential benefits and possible risks of vaccination. (5.3)

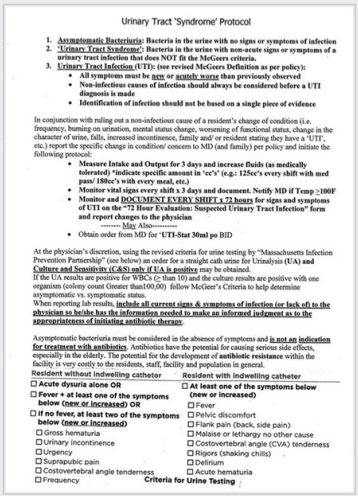
ADVERSE REACTIONS
In infants and toddlers vaccinated at 2, 4, 6, and 12–15 months of age in US clinical trials, the most commonly reported solicited adverse reactions were irritability (>70%), injection site tenderness (>50%), decreased appetite (>40%), decreased sleep (>40%), increased sleep (>40%), fever (>20%), injection site redness (>20%), and injection site swelling (>20%). (6.1)
In children aged 5 through 17 years, the most commonly reported solicited adverse reactions were injection site tenderness (>80%), injection site redness (>30%), injection site swelling (>30%), irritability (>20%), decreased appetite (>20%), increased sleep (>20%), fever (>5%), and decreased sleep (>5%). (6.1)
In adults aged 50 years and older the commonly reported solicited adverse reactions were pain at the injection site (>50%), fatigue (>30%), headache (>20%), muscle pain (>20%), joint pain (>10%), decreased appetite (>10%), injection site redness (>10%), injection site swelling (>10%), limitation of arm movement (>10%), chills (>5%) or rash (>5%). (6.2)

To report SUSPECTED ADVERSE REACTIONS, contact Wyeth Pharmaceuticals Inc. at 1-800-438-1985 or VAERS at 1-800-822-7967 or http://vaers.hhs.gov.

DRUG INTERACTIONS
In adults, antibody responses to Prevnar 13 were diminished when given with inactivated Influenza Virus Vaccine. (14.3)

USE IN SPECIFIC POPULATIONS
Pregnancy: Safety and effectiveness of Prevnar 13 in pregnant women have not been established. (8.1)
Pediatric Use: Safety and effectiveness of Prevnar 13 in children below the age of 6 weeks have not been established. (8.4)
Geriatric Use: Antibody responses to Prevnar 13 were lower in persons ≥65 years of age compared to antibody responses in persons 50 through 59 years of age. (8.5)
See 17 for PATIENT COUNSELING INFORMATION.
Revised: 1/2015

Prevnar 13 Prescribing Info



Urinary Tract 'Syndrome' Protocol

1. **Asymptomatic Bacteriuria: Bacteria in the urine with no signs or symptoms of infection**
2. **'Urinary Tract Syndrome': Bacteria in the urine with non-acute signs or symptoms of a urinary tract infection that does NOT fit the McGeers criteria.**
3. **Urinary Tract Infection (UTI): (see revised McGeers Definition as per policy):**
   - **All symptoms must be new or acutely worse than previously observed**
   - **Non-infectious causes of infection should always be considered before a UTI diagnosis is made**
   - **Identification of infection should not be based on a single piece of evidence**

In conjunction with ruling out a non-infectious cause of a resident's change of condition (i.e. frequency, burning on urination, mental status change, worsening of functional status, change in the character of urine, falls, increased incontinence, family and/ or resident stating they have a 'UTI', etc.) report the specific change in condition/ concern to MD (and family) per policy and initiate the following protocol:

- **Measure Intake and Output for 3 days and increase fluids (as medically tolerated) *indicate specific amount in 'cc's' (e.g.: 125cc's every shift with med pass/ 180cc's with every meal, etc.)**
- **Monitor vital signs every shift x 3 days and document. Notify MD if Temp ≥100F**
- **Monitor and DOCUMENT EVERY SHIFT x 72 hours for signs and symptoms of UTI on the "72 Hour Evaluation: Suspected Urinary Tract Infection" form and report changes to the physician**

------- May Also--------

- Obtain order from MD for '**UTI-Stat 30ml po** BID

At the physician's discretion, using the revised criteria for urine testing by "Massachusetts Infection Prevention Partnership" (see below) an order for a straight cath urine for Urinalysis **(UA) and Culture and Sensitivity (C&S) only if UA is positive** may be obtained.
If the UA results are positive for WBCs (≥ than 10) and the culture results are positive with one organism (colony count Greater than100,00) follow McGeer's Criteria to help determine asymptomatic vs. symptomatic status.
When reporting lab results, **include all current signs & symptoms of infection (or lack of) to the physician so he/she has the information needed to make an informed judgment as to the appropriateness of initiating antibiotic therapy.**

Asymptomatic bacteriuria must be considered in the absence of symptoms and **is not an indication for treatment with antibiotics**. Antibiotics have the potential for causing serious side effects, especially in the elderly. The potential for the development of **antibiotic resistance** within the facility is very costly to the residents, staff, facility and population in general.

Resident without indwelling catheter	Resident with indwelling catheter
☐ **Acute dysuria alone OR**	☐ **At least one of the symptoms below (new or increased)**
☐ **Fever + at least one of the symptoms below (new or increased) OR**	☐ Fever
☐ **If no fever, at least two of the symptoms below (new or increased)**	☐ Pelvic discomfort
☐ Gross hematuria	☐ Flank pain (back, side pain)
☐ Urinary incontinence	☐ Malaise or lethargy no other cause
☐ Urgency	☐ Costovertebral angle (CVA) tenderness
☐ Suprapubic pain	☐ Rigors (shaking chills)
☐ Costovertebral angle tenderness	☐ Delirium
☐ Frequency	☐ Acute hematuria
	Criteria for Urine Testing

Urinary Tract Syndrome Protocol

http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/icnc-revistingmcgeerdefinitions.pdf

http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/icnc-prevnar13-prescribinginfo.pdf

http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/icnc-urinarytractsymdromeprotocol.pdf

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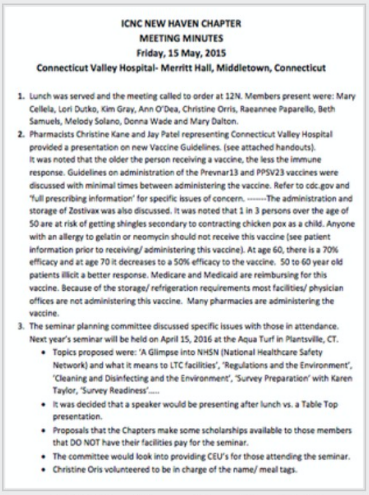
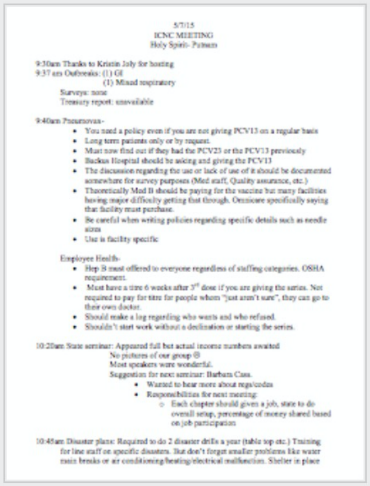


ICNC NEW HAVEN CHAPTER
MEETING MINUTES
Friday, 15 May, 2015
Connecticut Valley Hospital- Merritt Hall, Middletown, Connecticut

1. Lunch was served and the meeting called to order at 12N. Members present were: Mary Cellela, Lori Ducko, Kim Gray, Ann O'Dea, Christine Orris, Raeannee Paparello, Beth Samuels, Melody Solano, Donna Wade and Mary Dalton.
2. Pharmacists Christine Kane and Jay Patel representing Connecticut Valley Hospital provided a presentation on new Vaccine Guidelines. (see attached handouts). It was noted that the older the person receiving a vaccine, the less the immune response. Guidelines on administration of the Prevnar13 and PPSV23 vaccines were discussed with minimal times between administering the vaccine. Refer to cdc.gov and 'full prescribing information' for specific issues of concern. ------The administration and storage of Zostivax was also discussed. It was noted that 1 in 3 persons over the age of 50 are at risk of getting shingles secondary to contracting chicken pox as a child. Anyone with an allergy to gelatin or neomycin should not receive this vaccine (see patient information prior to receiving/ administering this vaccine). At age 60, there is a 70% efficacy and at age 70 it decreases to a 50% efficacy to the vaccine. 50 to 60 year old patients illicit a better response. Medicare and Medicaid are reimbursing for this vaccine. Because of the storage/ refrigeration requirements most facilities/ physician offices are not administering this vaccine. Many pharmacies are administering the vaccine.
3. The seminar planning committee discussed specific issues with those in attendance. Next year's seminar will be held on April 15, 2016 at the Aqua Turf in Plantsville, CT.
   - Topics proposed were: 'A Glimpse into NHSN (National Healthcare Safety Network) and what it means to LTC facilities', 'Regulations and the Environment', 'Cleaning and Disinfecting and the Environment', 'Survey Preparation' with Karen Taylor, 'Survey Readiness'.....
   - It was decided that a speaker would be presenting after lunch vs. a Table Top presentation.
   - Proposals that the Chapters make some scholarships available to those members that DO NOT have their facilities pay for the seminar.
   - The committee would look into providing CEU's for those attending the seminar.
   - Christine Oris volunteered to be in charge of the name/ meal tags.

ICNC-New Haven Mins. May 2015



5/7/15
ICNC MEETING
Holy Spirit- Putnam

9:30am Thanks to Kristin Joly for hosting
9:37 ers Outbreaks: (1) GI
(1) Mixed respiratory
Surveys: none
Treasury report: unavailable

9:40am Pneumovax-
- You need a policy even if you are not giving PCV13 on a regular basis
- Long term patients only or by request.
- Must now find out if they had the PCV23 or the PCV13 previously
- Backus Hospital should be asking and giving the PCV13
- The discussion regarding the use or lack of use of it should be documented somewhere for survey purposes (Med staff, Quality assurance, etc.)
- Theoretically Med B should be paying for the vaccine but many facilities having major difficulty getting that through. Omnicare specifically saying that facility must purchase.
- Be careful when writing policies regarding specific details such as needle sizes
- Use is facility specific

Employee Health-
- Hep B must offered to everyone regardless of staffing categories. OSHA requirement.
- Must have a titre 6 weeks after 3rd dose if you are giving the series. Not required to pay for titre for people whom "just aren't sure", they can go to their own doctor.
- Should make a log regarding who wants and who refused.
- Shouldn't start work without a declination or starting the series.

10:20am State seminar: Appeared full but actual income numbers awaited
No pictures of our group ☹
Most speakers were wonderful.
Suggestion for next seminar: Barbara Cass.
- Wanted to hear more about regs/codes
- Responsibilities for next meeting:
  - Each chapter should given a job, state to do overall setup, percentage of money shared based on job participation

10:45am Disaster plans: Required to do 2 disaster drills a year (table top etc.) Training for line staff on specific disasters. But don't forget smaller problems like water main breaks or air conditioning/heating/electrical malfunction. Shelter in place

ICNC-Eastern Mins. May 2015

It's a Brave New (Old) World

ICNC Annual Spring Seminar

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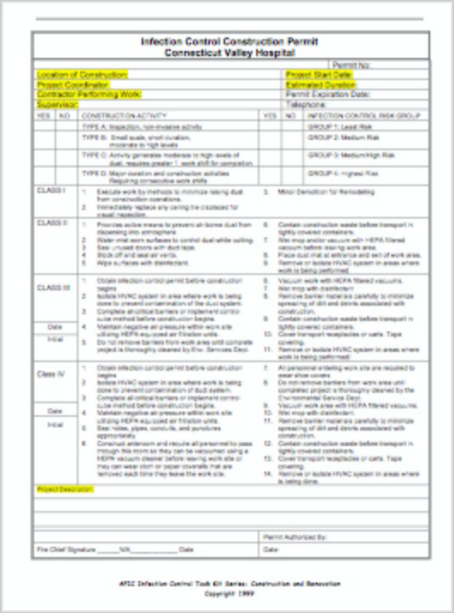
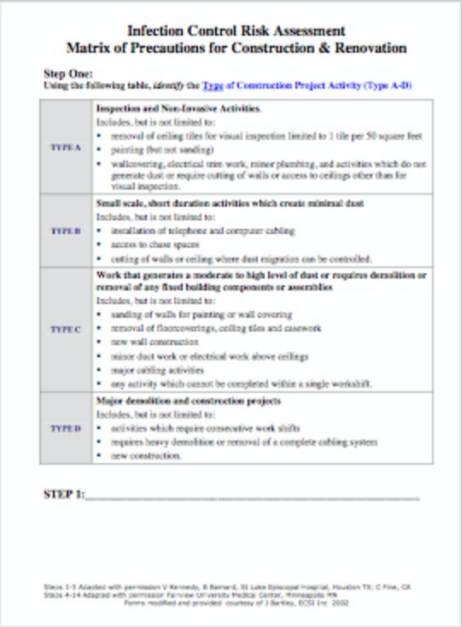


Infection Control Construction Permit
Connecticut Valley Hospital

Construction Permit



Infection Control Risk Assessment
Matrix of Precautions for Construction & Renovation

Step One:
Using the following table, identify the Type of Construction Project Activity (Type A-D)

TYPE A	**Inspection and Non-Invasive Activities** Includes, but is not limited to: • removal of ceiling tiles for visual inspection limited to 1 tile per 50 square feet • painting (but not sanding) • wallcovering, electrical trim work, minor plumbing, and activities which do not generate dust or require cutting of walls or access to ceilings other than for visual inspection.
TYPE B	**Small scale, short duration activities which create minimal dust** Includes, but is not limited to: • installation of telephone and computer cabling • access to chase spaces • cutting of walls or ceiling where dust migration can be controlled.
TYPE C	**Work that generates a moderate to high level of dust or requires demolition or removal of any fixed building components or assemblies** Includes, but is not limited to: • sanding of walls for painting or wall covering • removal of floorcoverings, ceiling tiles and casework • new wall construction • minor duct work or electrical work above ceilings • major cabling activities • any activity which cannot be completed within a single workshift.
TYPE D	**Major demolition and construction projects** Includes, but is not limited to: • activities which require consecutive work shifts • requires heavy demolition or removal of a complete cabling system • new construction.

STEP 1:_____

Matrix of Precautions for Construction & Renovation

http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/infectioncontrolconstructionpermit.pdf

http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/infectioncontrolconstructionrenovationriskassessment.pdf

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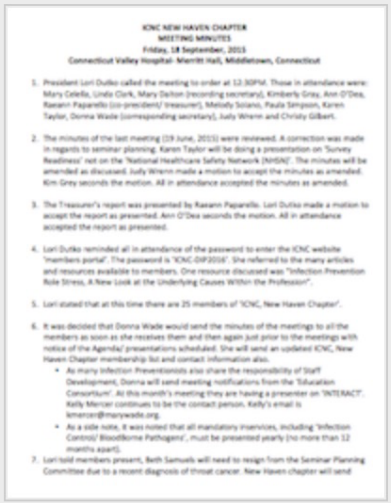
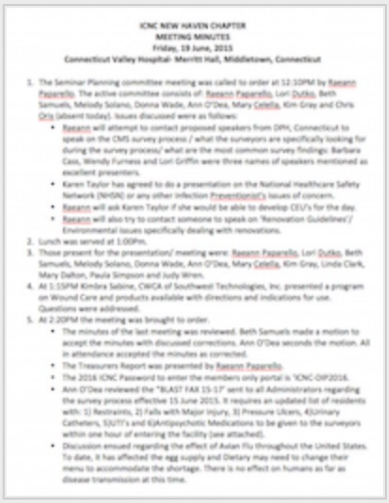


ICNC NEW HAVEN CHAPTER
MEETING MINUTES
Friday, 18 September, 2015
Connecticut Valley Hospital- Merritt Hall, Middletown, Connecticut

ICNC- New Haven Mins. Sept. 2015



ICNC NEW HAVEN CHAPTER
MEETING MINUTES
Friday, 19 June, 2015
Connecticut Valley Hospital- Merritt Hall, Middletown, Connecticut

ICNC- New Haven Mins. June 2015

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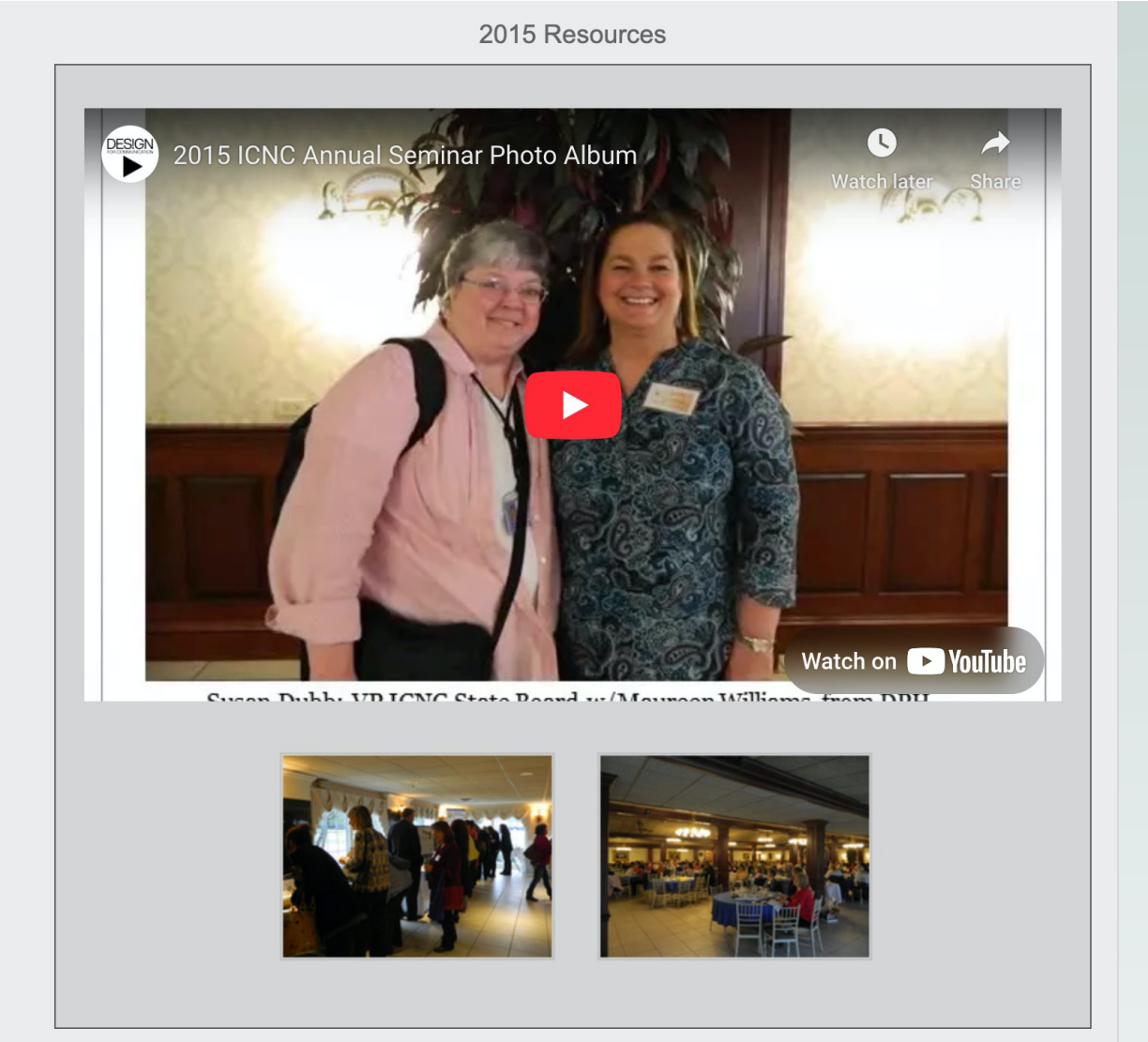

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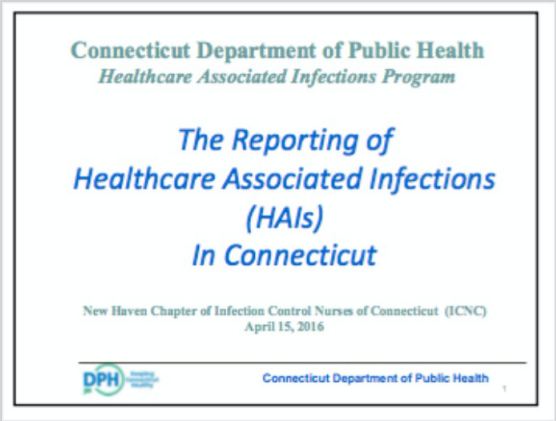
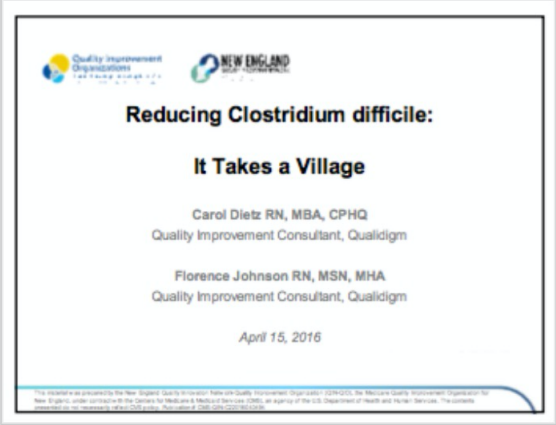
2016

2016 Seminar Powerpoint Presentations:

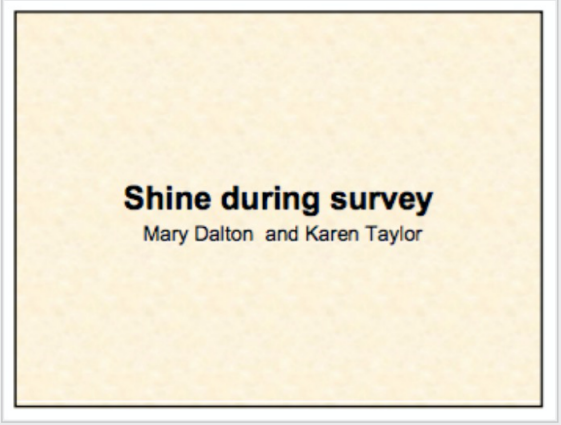


The Reporting of Healthcare Associated Infections (HAIs) In Connecticut

Nursing Home Infection Prevention and Control Program Changes Ahead



Reducing Clostridium Difficile: It Takes a Village



Shine During Survey

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http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/qualidigmcdiffpp.pdf

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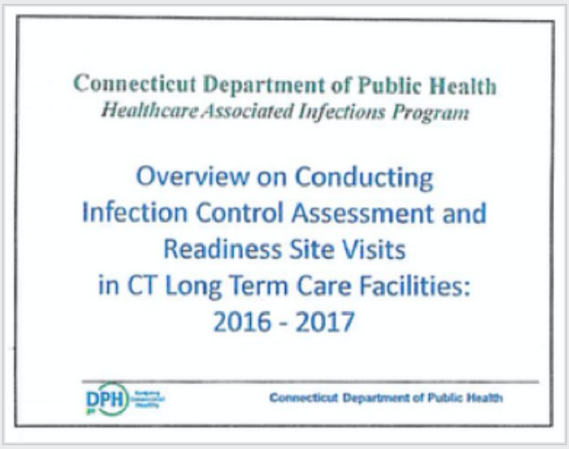
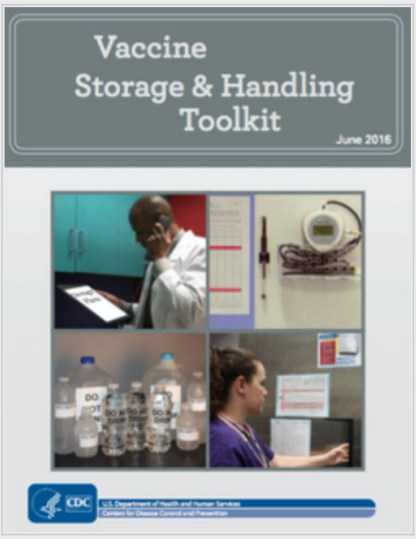
CDPH: Infection Control Assessment



2016 - 2017

Vaccine Storage & Handling - June 2016



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http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/storage-handling-toolkit.pdf

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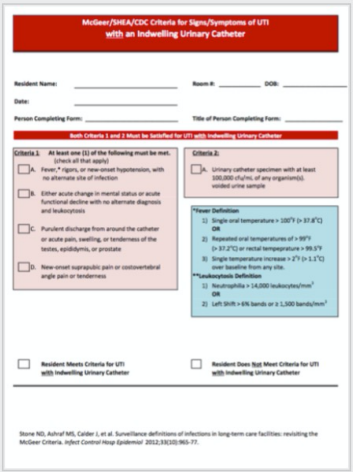
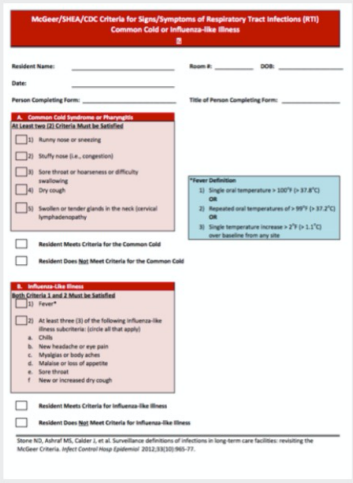
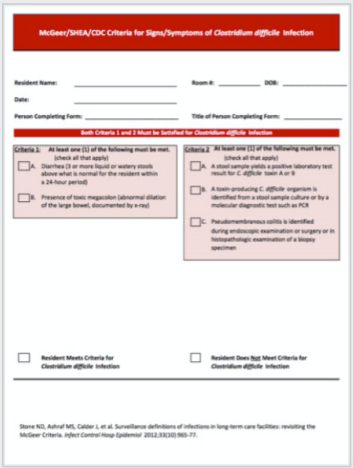


McGeer/SHEA/CDC Criteria for Signs/ Symptoms of UTI with an Indwelling Urinary Catheter





McGeer/SHEA/CDC Criteria for Signs/ Symptoms of Clostridium difficile Infection

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http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/mcgeercriteriaclostridium.pdf

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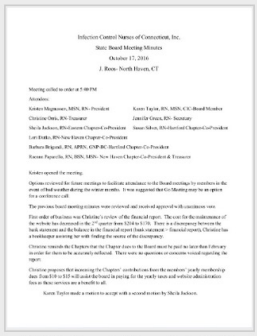
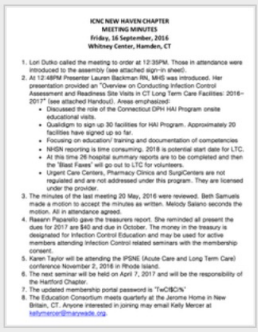
Eastern Chapter Mins. Jan 2017



ICNC-Board Mins. Oct 2016



New Haven Chapter Mins. Sept. 2016

Eastern Chapter Mins. Mar 2016

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http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/newhavenchaptersept2016mins.pdf

http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/easternmarch2017mins.pdf

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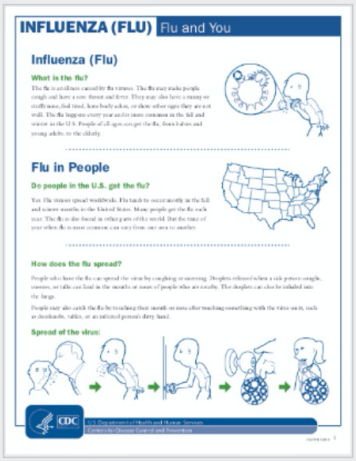
2017

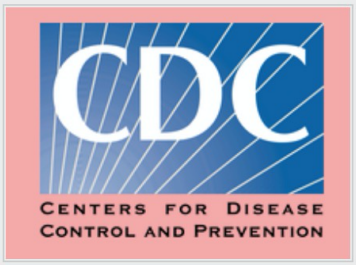
Contamination



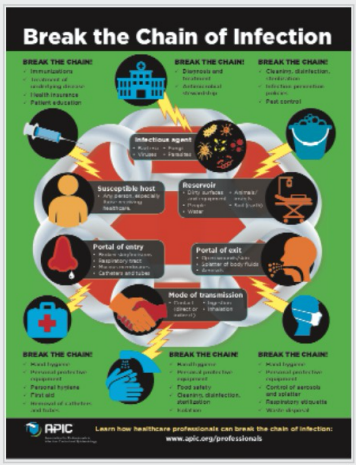
The Flu and You

Do's & Don'ts Healthcare Environment

Cdiff



Assessment Tool



Break the Chain of Infection

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http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/cdc_ic_assessment_tool_ltcf_2016.pdf

http://www.infectioncontrolct.org/uploads/2/6/2/4/26245608/break-the-chain-of-infection.pdf