Infection Prevention Webinar Series:

Non-Ventilator Pneumonia

December 18, 2019
• Welcome & FHA Mission to Care HIIN Update
• Upcoming HIIN Events and Opportunities
  – Cheryl Love, RN, BSN, BS-HCA, MBA, LHRM, CPHRM, Director of Quality and Patient Safety and Improvement Advisor, FHA
• Infection Prevention Series: Non-ventilator Pneumonia
  – Linda R. Greene, RN, MPS, CIC, FAPIC, Manager of Infection Prevention, UR Highland Hospital, Rochester, NY
• Q&A
• Evaluation Survey & Continuing Nursing Education
HIIN Core Topics – Aim is 20% reduction

- Adverse Drug Events (ADE)
- Catheter-associated Urinary Tract Infections (CAUTI)
- Clostridium Difficile Infection (CDI)
- Central line-associated Blood Stream Infections (CLABSI)
- Hospital-onset MRSA Bacteremia
- Injuries from Falls and Immobility
- Pressure Ulcers (PrU)
- **Sepsis – Post-Op**
- Surgical Site Infections (SSI) – Colon
- Venous Thromboembolisms (VTE)
- Ventilator-Associated Events (VAE/IVAC/PVAP)
- Readmissions (12% reduction)
- Worker Safety
Post-Op Sepsis Resources, Trainings and Tools

- Mission to Care Website
- HRET HIIN Website

- FHA Sepsis Toolkit 2019
- Sepsis Change Package
- Sepsis Checklist
- Sepsis Readmissions Lessons Learned Report
- Post-Op Sepsis SNAP Summary Webinar
- FHA Event Archives
- HRET HIIN Resource Library
# Our Progress

## Summary of Progress Meeting 20/12 Goal:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Project-to-Date: October 2015 to Present</th>
<th>Most Recent 3 Months</th>
<th>Hospital Target</th>
<th>Top 25th Percentile Project to Date</th>
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<tbody>
<tr>
<td>SEPSIS</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Post-op Sepsis</td>
<td>Baseline: 6.343</td>
<td>1,315</td>
<td>308,502</td>
<td>4.263</td>
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<tr>
<td>CAUTI</td>
<td>CAUTI Rate - all except NICUs</td>
<td>0.975</td>
<td>1,521</td>
<td>2,006,517</td>
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<td>CAUTI Rate - ICUs except NICUs</td>
<td>1.090</td>
<td>751</td>
<td>922,277</td>
<td>0.814</td>
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<td>C. diff Rate Facility-wide-all except NICUs (per 10,000)</td>
<td>7.453</td>
<td>5,619</td>
<td>14,273,938</td>
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<td>CLABSI</td>
<td>CLABSI Rate - All</td>
<td>0.924</td>
<td>1,333</td>
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<td>CLABSI Rate - ICUs</td>
<td>0.858</td>
<td>511</td>
<td>789,079</td>
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<td>MRSA</td>
<td>Hospital-acq MRSA bacteremia events</td>
<td>0.070</td>
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<td>15,000,969</td>
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<td>SSI</td>
<td>SSI rate, colon surgeries*</td>
<td>4.034</td>
<td>1,185</td>
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<td>SSI rate, abdominal hysterectomy*</td>
<td>1.509</td>
<td>318</td>
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<td>SSI rate, knee surgeries*</td>
<td>0.732</td>
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<td>1.421</td>
<td>416</td>
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<td>VAE</td>
<td>Ventilator-associated condition rate</td>
<td>6.600</td>
<td>2,870</td>
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<td>Infection-related ventilator-associated condition rate</td>
<td>2.212</td>
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<td>305,640</td>
<td>1.835</td>
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<td>Possible ventilator associated pneumonia</td>
<td>0.754</td>
<td>264</td>
<td>350,517</td>
<td>0.753</td>
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</table>

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* Rate calculated per 100

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Effective Date: December 2, 2019

All measures calculated per 1,000 unless noted.

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FHA HIIN
Hospital Performance Report

Mission to Care. Vision to Lead.
<table>
<thead>
<tr>
<th>Harm Measure</th>
<th>Baseline Rate per 1000</th>
<th>Target Rate</th>
<th>Project To Date Rate per 1000 Discharge</th>
<th>Harms Prevented</th>
<th>Costs Avoided</th>
<th>Lives Saved</th>
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<tbody>
<tr>
<td>Post-Op Sepsis Rate</td>
<td>0.72</td>
<td>0.57</td>
<td>0.49</td>
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<td>CAUTI Rate - All Settings</td>
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<td>0.58</td>
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<td>CLABSI Rate - All Settings</td>
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<td>SSI Rate, Colon</td>
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<td>0.42</td>
<td>19</td>
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<td>SSI Rate, Abd</td>
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<td>0.10</td>
<td>0.11</td>
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<td>$384,308</td>
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<td>SSI Rate, Knee</td>
<td>0.16</td>
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<td>75</td>
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<td>SSI Rate, Hip</td>
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<td>0.16</td>
<td>0.16</td>
<td>110</td>
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<td>Clostridioides difficile rate</td>
<td>3.56</td>
<td>2.85</td>
<td>2.01</td>
<td>4,105</td>
<td>$70,858,933</td>
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<td>VAC</td>
<td>1.25</td>
<td>1.00</td>
<td>1.04</td>
<td>546</td>
<td>$25,814,809</td>
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Source: HRET Improvement Calculator, effective date December 2, 2019
Infection Prevention Virtual Series

<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
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<tbody>
<tr>
<td>NHSN: SSI Surveillance Identification and Analysis</td>
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<tr>
<td>SSI-Colon: How to Assess Root Cause and Prevention Strategies</td>
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<tr>
<td>NHSN: VAE Surveillance Identification and Analysis</td>
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</tr>
<tr>
<td>VAE: How to Assess Root Cause and Prevention Strategies</td>
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</tr>
<tr>
<td>NHSN: MRSA Bacteremia Surveillance Identification and Analysis</td>
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<tr>
<td>MRSA Bacteremia: How to Assess Root Cause and Prevention Strategies</td>
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<tr>
<td>Implementation of Best Practices for VAE Prevention</td>
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<tr>
<td>Implementation of Strategies for the Prevention of IVAC/PVAP</td>
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<tr>
<td>Decreasing Surgical Site Infections in Abdominal Hysterectomy Patients</td>
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<tr>
<td>Strategies to Prevent Hospital-onset MRSA Bloodstream Infections</td>
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<tr>
<td>Decreasing Surgical Site Infections in Colon Surgery Patients</td>
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</tbody>
</table>

**Surgical Infection Prevention Webinar Series:**

| Webinar #1: Pre-operative Strategies for Prevention of SSI             | Preventing Post-Surgical Harm Resource Guide                                 |
| Webinar #2: Intra-operative Strategies for Prevention of SSI           |                                                                            |
| Webinar #3: Post-operative Strategies for Prevention of SSI           |                                                                            |

*Access Event Archives (Recordings | Slides) on the Mission to Care HIIN Website*
Upcoming Virtual Events

Jan. 7 @ 1-2 p.m. ET - HRET HIIN | PFE What Matters to You? Series: Session 4

Jan. 16 @ 2-3 p.m. ET - FHA HIIN | Readmissions Reboot Session 3: Delivering Enhanced Services Based on Need to Decrease Preventable Readmissions

Jan. 24 @ 12-1 p.m. ET - FHA HIIN | Infection Prevention Webinar: Waterborne Illness in Hospitals - Prevention, Identification and Management

Feb. 18 @ 2-3 p.m. ET - FHA HIIN | Readmissions Reboot Session 4: Collaborating with Providers and Agencies across the Continuum to Decrease Preventable Readmissions

Feb. 19 @ 12-1 p.m. ET - FHA HIIN | Infection Prevention Webinar: SSI Prevention for Total Joint Replacements

Mar. 17 @ 2-3 p.m. ET - FHA HIIN | Readmissions Reboot Session 5: Partnering with our High Utilizer Patients and their Families to Decrease Preventable Readmissions

Mar. 2020 – IP Series Webinar (Date & Topic TBA)

Check your HIIN Mission to Care Newsletter Weekly Email for more event details and registration
Upcoming In-Person Events

Jan. 9, 2020 | Harry P. Leu Gardens, Orlando
FHA | AHRQ ICU Safety Program: Celebrating Safety Culture, Success and Sustainability in ICU

Jan. 16-17, 2020 | FHA Corporate Office, Orlando
FHA HIIN | Infection Prevention Boot Camp I for the Novice Infection Preventionist

Feb. 13, 2020 | Harry P. Leu Gardens, Orlando
FHA / MHA | Critical Care: Collaborating for Quality, Safety and Best Practices

Check your HIIN Mission to Care Newsletter Weekly Email for more event details and registration
NV-HAP

Linda R. Greene, RN, MPS,CIC,FAPIC
Manager, Infection Prevention
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Rochester, NY
linda_greene@urmc.rochester.edu
Objectives

- Identify the importance of NV-HAP
- Discuss current definitions and future opportunities
- Identify prevention strategies
Polling Question

What is your background?
1. Infection Prevention
2. Quality / Patient Safety
3. Staff nurse
4. Management
5. Other
Polling Question

What are the 2 most common HAIs?

1. CAUTI and Pneumonia
2. Pneumonia and SSIs
3. CAUTI and GI infections
4. Pneumonia and GI infections
Background

Magill and colleagues conducted a point prevalence study in several states through the Emerging Infections Program (EIP) sites.

The Emerging Infections Program (EIP) is a collaboration between CDC and 10 state health departments working with academic partners to conduct active population-based surveillance and special studies for several emerging infectious diseases with special emphasis on infectious diseases related to the key EIP activities.

The EIP sites are funded through a cooperative agreement, are designed to foster relationships between local public health departments and academic centers.
New Point Prevalence Studies

- 2015 – decreases in SSI and CAUTI
- Pneumonia and GI infections (Clostridioides difficile)
- Pneumonia findings:
  “Although the prevention of ventilator-associated pneumonia remains an important goal, the majority of pneumonia events in hospitals in our survey were not ventilator-associated.”

Magill et al, NEJM Nov 2108
Studies from other Countries

- Both Europe and Australia report similar findings

- Data suggests mortality is equal in ventilated and non ventilated patients

- Few organizations routinely monitor and report NV-HAP
Cost and Mortality

- Using Healthcare Utilization Project (HCUP) data
  - Preventing 100 cases of NVHAP → save up to $4 million
  - 700-900 hospital days
  - 20-30 lives (Giuliano et al. 2016)

- Literature average cost per case ranges $28,000 - $40,000

- Mortality 14.5-30.9%
PRACTICE POSITION STATEMENT APIC
Non-Ventilator Healthcare-Associated Pneumonia (NV-HAP)

AUTHORS
Dian Baker, PhD, RN
James Davis, MSN, RN, CCRN-K, CIC, HEM, FAPIC
Barbara Quinn, MSN, RN, ACNS-BC

SUMMARY
APIC encourages infection preventionists to understand and apply the current CDC NV-HAP surveillance definitions in selected patient populations in order to establish prevalence rates. APIC calls on healthcare systems, clinical providers and infection preventionists to:
• Reduce the incidence of NV-HAP with appropriate interventions targeted to specific patient populations;
• Support process improvement efforts;
• Support research, to identify highest risk populations and methods of active surveillance for a proactive response to reducing NV-HAP incidence.

Barriers

• Current NHSN definitions are complex
• Case finding methodologies are difficult
• Chest x-ray reports lack standardization
Figure 1: Pneumonia Flow Diagram for Patients of Any Age

1. **Imaging**
   - Patient with underlying disease
     1.1.4.
   - Pneumonia
   - New or persistent
   - Progressive and persistent
   - Chest x-ray
   - Consolidation
   - Cavity
   - Pneumatocele

2. **Signs & Symptoms**
   - At least one of the following:
     2.1.1. Fever (≥38.0°C/100.4°F)
     2.1.2. Leukocytosis (≥10,000 WBC/mm³) or leukopenia (≤4,000 WBC/mm³)
     2.1.3. Altered mental status with no other cause

3. **Laboratory**
   - Organism identified from blood
   - Organism identified from pleural fluid
   - Positive quantitative culture of corresponding semiquantitative result from normally contaminated LRT specimen
   - 70% BAL-obtained cells contain intracellular bacteria
   - Positive quantitative culture of corresponding semi-quantitative result of lung parenchyma
   - Histopathologic exam shows at least one of the following:
     3.1.1. Abscess formation
     3.1.2. Foul odor of consolidation
     3.1.3. Infiltrate in bronchovascular bundles
     3.1.4. Evidence of lung parenchymal invasion by fungal hyphae or pseudohyphae

4. **PNU1**
5. **PNU2**
6. **PNU3**

7. **Immunocompromised**
Polling Question

Do you Perform Surveillance for NV- HAP?

1. Yes
2. No
Ten candidate definitions for NV-HAP based on clinically meaningful combinations of 6 potential surveillance criteria were proposed:

- Worsening oxygenation
- Temperature higher than 38°C (fever)
- Abnormal white blood cell count of less than 4000/µL or more than 12 000/µL,
- Chest imaging order
- Respiratory specimen for culture ordered
- 3 or more days of new antibiotics.
Drilling Down on Measures

Potential Definition:

Worsening oxygenation (most important variable)
Fever or abnormal WBC
3 or more days of new antibiotics
Chest x-ray ordered

Found rate of 0.6 events per 100 admissions similar to other literature
CDC

Evaluating less burdensome measure
Incidence

Narrative Review

Although preventive measures for ventilator-associated pneumonia (VAP) are well known, less is known about appropriate measures for prevention of hospital-acquired pneumonia (HAP)

Patients with NV-HAP have equal mortality as VAP

Less known about prevention of NV-HAP than VAP

Passaro *Antimicrobial resistance and Infection control* Nov. 2016
Risks

Dysphagia – most important risk factor for pneumonia

Important in elderly and stroke patients

Viral infections (i.e. influenza)

Found heterogeneity of prevention measures
The Literature

Risk Factors for NV-HAP

- Elderly
- Malnutrition
- Altered mental status
- Central Nervous System depressants
- H2 Blockers
Other Risks

- Enteral feedings
- Post-operative aspiration
- Immunocompromised patients
- Stress ulcer prophylaxis
There are three causes for aspirations that lead to aspiration pneumonia:

1. Oro gastric secretions in patients with marked disturbance of consciousness. For example, acute neurological insult including stroke or head trauma.

2. Misdirected orally ingested liquids and/or foods due to swallowing difficulties secondary to a medical condition or intervention.
   - Progressive neurological illnesses including Parkinson’s disease
   - ALS
   - Tumors of the head-neck head and neck cancer treatments such as surgical ablation and radiation therapy
   - Damage to the laryngeal area following prolonged endotracheal intubation.

3. Misdirected orally ingested liquids and/or foods due to aging process.

Non ventilator hospital-acquired pneumonia (NV-HAP) is an underreported and unstudied disease.

Used International Statistical Classification of Diseases and Related Problems (ICD-9) codes for pneumonia not present on admission and verified NV-HAP diagnosis using the U.S. Centers for Disease Control and Prevention diagnostic criteria.

Determine effectiveness of oral care.

Conclusion: NV-HAP should be elevated to the same level of concern, attention, and effort as prevention of ventilator-associated pneumonia in hospitals.
Having the Right Products
In Hospitals, Pneumonia Is a Lethal Enemy

Basic nursing care could curb the top hospital-acquired infection in America, a new study says

BY LUCETTE LAGNADO

AT A TIME WHEN the public is concerned with drug-resistant superbugs, researchers have identified another danger of going to the hospital: contracting pneumonia.
Pneumonia and the oral cavity

- For pneumonia to develop, the pathogen must be aspirated from a proximal site (for example, the oropharyngeal cavity) into the lower airway.

- A person with teeth or dentures has non-shedding surfaces on which oral biofilms form.

- These biofilms are susceptible to colonization by respiratory pathogens.

- Poor oral hygiene may predispose high-risk patients to oral colonization by respiratory pathogens.
Oral Microbiota

Preventing hospital-acquired pneumonia

**Germs in mouth**
- Provide comprehensive oral care for all patients: the right equipment, protocols, education.

**Aspiration**
- Use aspiration prevention strategies.
- Recognize microaspiration risks and need for clean mouth.

**Weak host**
- Strengthen host defenses, promote early mobility, and encourage coughing and deep breathing.
- Regulate glucose level, provide adequate nutrition, monitor use of histamine-2 blockers and proton pump inhibitors.

**Prevention of HAP**

[Link to source](https://www.americannursetoday.com/wp-content/uploads/2015/03/ant3-CE-Oral-Care-225.pdf)
Quinn and Baker
Can a structured oral care program reduce infection incidence?

Dental decay and poor oral hygiene are risk factors for pneumonia.

- Determine incidence of VAP for stroke
- Structured oral intervention:
  - Used risk screen >6

Mechanical cleansing with suction toothbrush every 12 hours

Antiseptic mouthwash

Talley et.al  Nursing Management 2016
HAP risk. Criteria for HAP risk assessment were developed and optimized for this study. Post-intervention patients were assessed every 12 hours for oral status and deemed low risk (score 0-5) or high risk (score >6). Patients with nasal or gastric tubes, swallowing disorders, aspiration history, oral suctioning, continuous NPO status, bi-level positive airway pressure masks, or tracheostomy were automatically considered high risk for HAP and received a score of 6. In the absence of these conditions, patients received a score of 0 to 2, with 0 being normal and 2 severe, for each of the following: condition of the gums, condition of the lips/corners of the mouth, swallowing and chewing ability, and feeding/oral care ability. For each patient, the scores were combined and recorded as the patient’s HAP risk score.

NPO status was defined operationally as preventing the patient from any oral intake in the form of nutrition, medication, ice chips, or sips of water. NPO days represented those days that the patient was at high risk for aspiration of nutrition or medication via the oral route.
### Table 3: Incidence of patients with HAP

<table>
<thead>
<tr>
<th>Variables</th>
<th>Progressive care unit</th>
<th>Stroke care unit</th>
<th>Med</th>
<th>Med</th>
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<tr>
<td>Preintervention (n = 347)</td>
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<td>0</td>
<td>0</td>
<td>6</td>
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<tr>
<td>Postintervention (n = 337)</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
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</tbody>
</table>

Talley et.al  *Nursing Management* 2016
Understanding the pathophysiology of postoperative pneumonia

- Postoperative mucus plugs and decreased surfactant production are directly related to anesthetic agents, hypoventilation, immobility, ineffective coughing, and extensive smoking history, which lead to atelectasis.

- Due to the effect of anesthetic agents, concentrated oxygen, and position during surgery, the patient can develop absorption atelectasis and impaired surfactant, which leads to a reduction in alveolar surface tension. Lung expansion is compromised.

- Most patient positions during the intraoperative period contribute to shifting of abdominal viscera upward toward the diaphragm. This results in upward displacement of the diaphragm. These alterations reduce ventilatory force and tidal volume.

- Patient risk factors, including anesthetics and smoking, favor colonization of microorganisms that triggers an acute inflammatory and immune response and subsequent increased mucus production, respiratory membrane thickening, increased work of breathing, and impaired gas exchange.
Post Surgery Pneumonia

Surgical patients are predisposed to developing lower respiratory tract infections due to a combination of:

- **Reduced chest ventilation** – reduced mobility in bedridden patients results in an inability to fully ventilate their lungs, leading to accumulation of fluid secretions which subsequently become infected.

- **Change in commensals** – the hospital environment microflora will vary compared to what the patient may normally be exposed to.

- **Debilitation** – many patients undergoing surgery are likely to be sick or have several co-morbidities, compromising their immune systems and predisposing to pulmonary infections.
Post –Op Risk Reduction Strategies

- HOB or in chair for eating
- Early mobility
- Tooth brushing and mouth care
Nutrition

Enteral versus parenteral nutrition and enteral versus a combination of enteral and parenteral nutrition for adults in the intensive care unit (Review) Cochrane review Lewis et al 2018

Cochrane Review – Malnutrition is associated with morbidity and mortality

Patients unable to be fed

No difference in outcomes between those patients who receive enteral vs parenteral
Comparisons between intragastric and small intestinal delivery of enteral nutrition in the critically ill: a systematic review and meta-analysis

- Small bowel feeding may be associated with a reduction in ICU-acquired pneumonia and increases in nutrient delivery, but days of ventilation, ICU and hospital stay and mortality were unaffected.

- The route of enteral nutrient administration (intragastric or small intestinal) does not appear to be a major determinant of mortality or length of stay in unselected critically ill patients.

- The small bowel approach may reduce the incidence of pneumonia in some patients.

Deane A et al. Critical Care 2013, 17
ESPEN guideline on clinical nutrition in the intensive care unit

2019 Guidelines:

- Oral diet shall be preferred over EN or PN in critically ill patients who are able to eat.

- If oral intake is not possible, early EN (within 48 h) in critically ill adult patients should be performed/initiated rather than delaying EN.

- In case of contraindications to oral and EN, PN should be implemented within three to seven days.

- Gastric access should be used as the standard approach to initiate EN.

- In patients with gastric feeding intolerance not solved with prokinetic agents, post pyloric feeding should be used.
Early Mobility Bundle

- Early mobility and physical therapy in hip fractures has been shown to reduce the incidence of pneumonia
- Effect on medical patients is less known
- UK study: 1 elderly care ward, 1 respiratory ward compared
- Targeted physical therapy and staff mobilization
- NV: HAP incidence lower in control group P<.004, Lower LOS

Mobility Bundle

Walking Aids
Mobility charts
Occupational therapy equipment
Instructions above bed

Stolbrink, Journal of Hospital Infection 2014
What about Bundles?

ID WEEK 2019 (Kaiser Permanente) 7 interventions:

- Aggressive mobilization
- Swallowing evaluation before feeding
- Elevated head of bed
- Limit sedation
- Oral care
- Upright posture for meals
- Tube feeding care
Results

- Rate decreased from 5.92 to 1.79 per 1,000 admissions
- HAP mortality decreased from 1.05 to 0.34 per 1000 admissions

Polling Question

Do you have a robust policy and procedure for mouth care of non ventilated patients?

1. Yes

2. No
Basic Prevention Measures

- Immunization
- Hand Hygiene
- Mouth Care
- Antibiotic stewardship
Getting Started

High Risk area examples:

- Admissions to ICU with respiratory issues
- Oncology units
- Post-operative units
- Specific geriatric or medical units
Questions
Eligibility for Nursing CEU requires submission of an evaluation survey for each participant requesting continuing education:

https://www.surveymonkey.com/r/IP12182019

Share this link with others on your team if viewing today’s webinar as a group (Survey closes Dec 28, 2019)

Be sure to include your contact information and Florida nursing license number

FHA will report 1.0 credit hour to CE Broker and a certificate will be sent via e-mail (Please allow at least 2 weeks after the survey closes)
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