
Healthcare-Associated Outbreaks: What to Expect?

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Healthcare-Associated Infections Program

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The logo for the Oregon Health Authority, featuring the word "Oregon" in a small serif font above the word "Health" in a large serif font, with the word "Authority" in a smaller serif font below "Health".

Oregon
Health
Authority

Objectives

- Define a suspected outbreak
- Roles & responsibilities
- Detect & Respond
- Provide examples of healthcare-associated outbreaks reportable to public health

What is reportable?

- Any case of a reportable disease* and, if unsure:
 - Highly transmissible, serious or severe health consequences
- “...any known or suspected common-source outbreaks; any uncommon illness of potential public health significance,” whether or not a reportable disease

Who must report?

- Each healthcare provider *or any individual knowing of such a case*

<https://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/ReportingCommunicableDisease/Pages/rules.aspx>

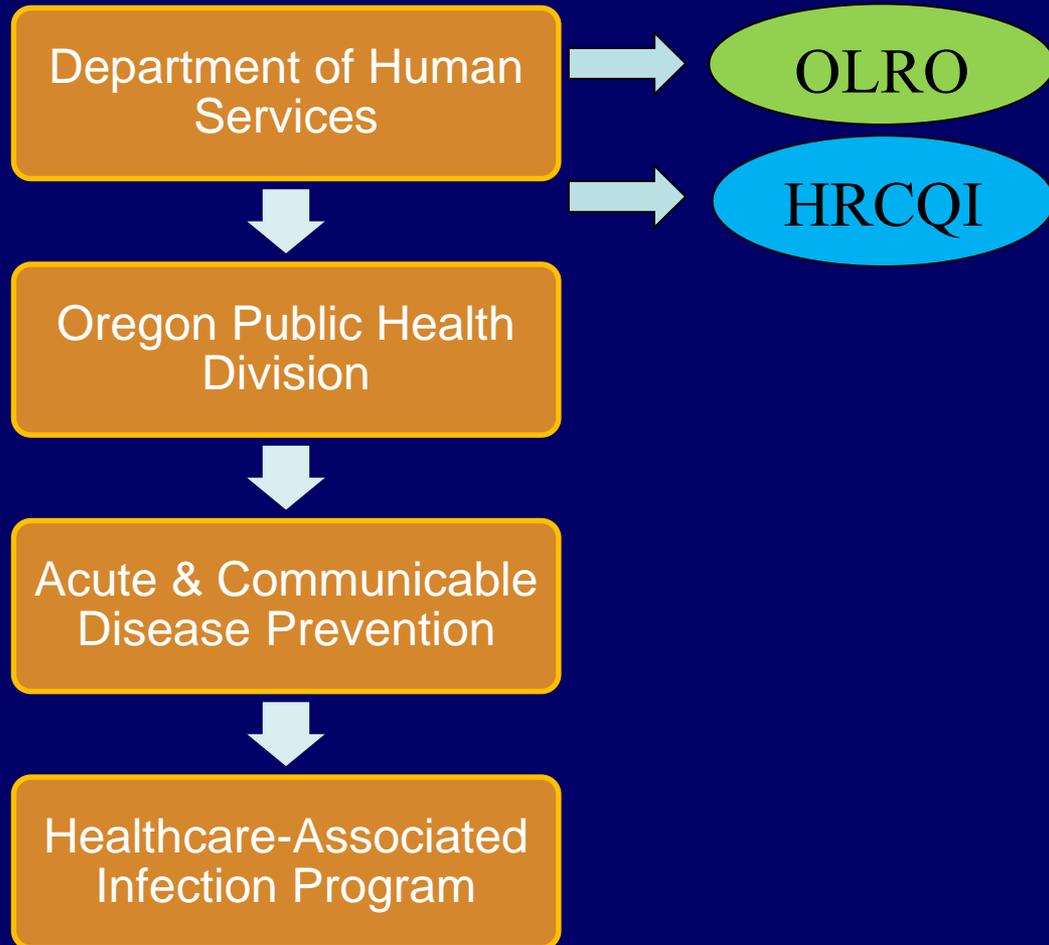
What makes an HAI outbreak?

- Two or more cases of disease
- Epidemiologically-linked
- Occurring in a healthcare facility
- Reportable by the facility (ORS 442.015)
 - Hospital
 - Long term care facility
 - Ambulatory surgical center
 - Freestanding birthing center
 - Outpatient renal dialysis center



ROLES & RESPONSIBILITIES

Who are we?



What does acute & communicable disease do?

“We’re the government,
but not *that* part of the government.”

– Bill Keene
epidemiologist extraordinaire

Epidemiologists



What my friends think I do



What my parents think I do



What society thinks I do



What grandma thinks I do



What I think I do



What I really do

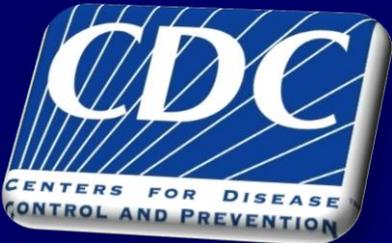
Protect Oregonians' Health

- **Surveillance**
 - Carbapenem-resistant Enterobacteriaceae (CRE)
- **Reporting**
 - Communicable Disease Reporting
 - National Health Safety Network for healthcare-associated infections
- **Support regulations to prevent disease**
 - License healthcare facilities & providers
- **Prevention and Response**
 - Vaccines, Collaborations, Outbreaks, Coordination, Expertise

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Our Partners



OREGON PUBLIC HEALTH
Acute & Communicable Disease Prevention



What is the role of Local Health Departments?

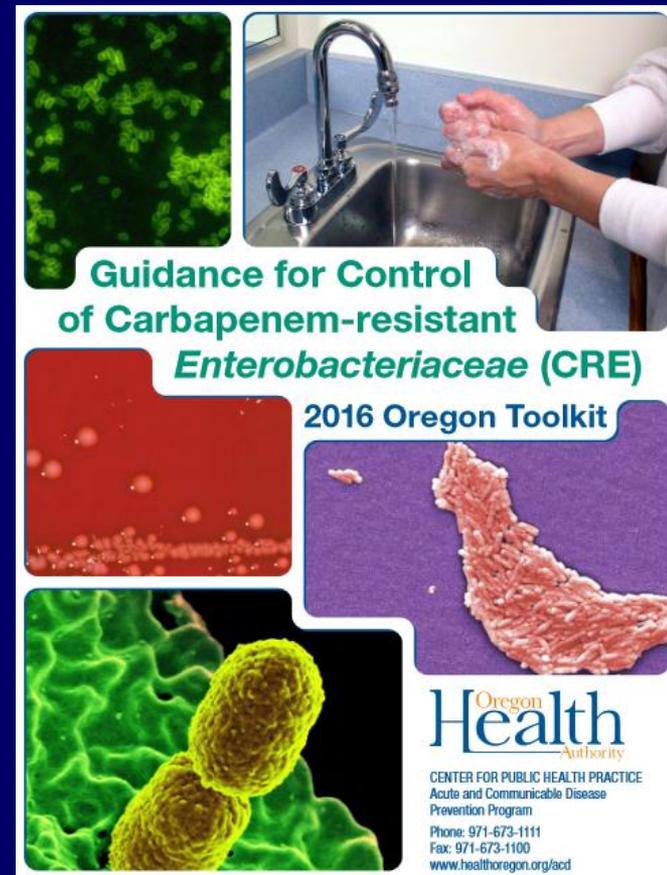


Oregon Coalition of Local Health Officials

- Know their community
- Interview cases
- Investigate outbreaks
- Perform public health roles for the community
 - Vaccines, Women Infants & Children
 - Prevent chronic disease
 - Environmental health

Carbapenem-resistant Enterobacteriaceae

- Since 2011
- Local health departments interview cases
- Screen co-residents to ensure transmission has not occurred
- Provide update input
- Stay tuned for webinar!



Summary of recommendations for management of SNF residents with CRE

Measure	CP-CRE infection	CP-CRE colonization	Non-CP-CRE infection	Non-CP-CRE colonization ^{††}
Notify receiving facility*	Yes	Yes	Yes	Yes
Notify county health upon transfer or death	Yes	Yes	No	No
Standard precautions	Yes	Yes	Yes	Yes
Contact precautions [†] Gown/gloves for in-room resident care	Yes	Yes	Yes	For residents at higher risk of CRE transmission
Door signage	Yes	Yes	Yes	For residents at higher risk of CRE transmission
Private room	Yes (strongly encouraged)	Yes (strongly encouraged)	Yes	No
Restricted to room	Yes	No ^{**}	No ^{**}	No ^{**}
Enhanced environmental cleaning	Yes	Yes	Yes	No
Designated or disposable equipment	Yes	Yes	Yes	No
If >1 case, cohort staff if feasible	Yes	Yes	Optional	Optional
If >1 case, cohort residents if feasible	Yes	Yes	Optional	Optional
Consult with OHA regarding screening cultures	Yes	Yes	No	No
Visitor recommendations:				
• Perform hand hygiene often, particularly after leaving the resident's room.	Yes	Yes	Yes	Yes
• Gown/gloves if contact with body fluids is anticipated.	Yes	Yes	Yes	Yes
• Gown/gloves if no contact with body fluids is anticipated.	No	No	No	No

Tattoo: Water contamination causing non-tuberculous mycobacterial infection



OREGON PUBLIC HEALTH
Acute & Communicable Disease Prevention

Oregon
Health
Authority

What is the role of Healthcare Facilities and Providers?

- **Prevent**
 - Practice best practices and current recommendations
 - Practice infection prevention, antimicrobial stewardship
- **Be alert**
 - Eyes and Ears of public health
 - Clusters of illness? Novel disease?
- **Test**
 - Cultures important to link cases
- **Report & Respond**
 - Reportable diseases
 - Outbreaks



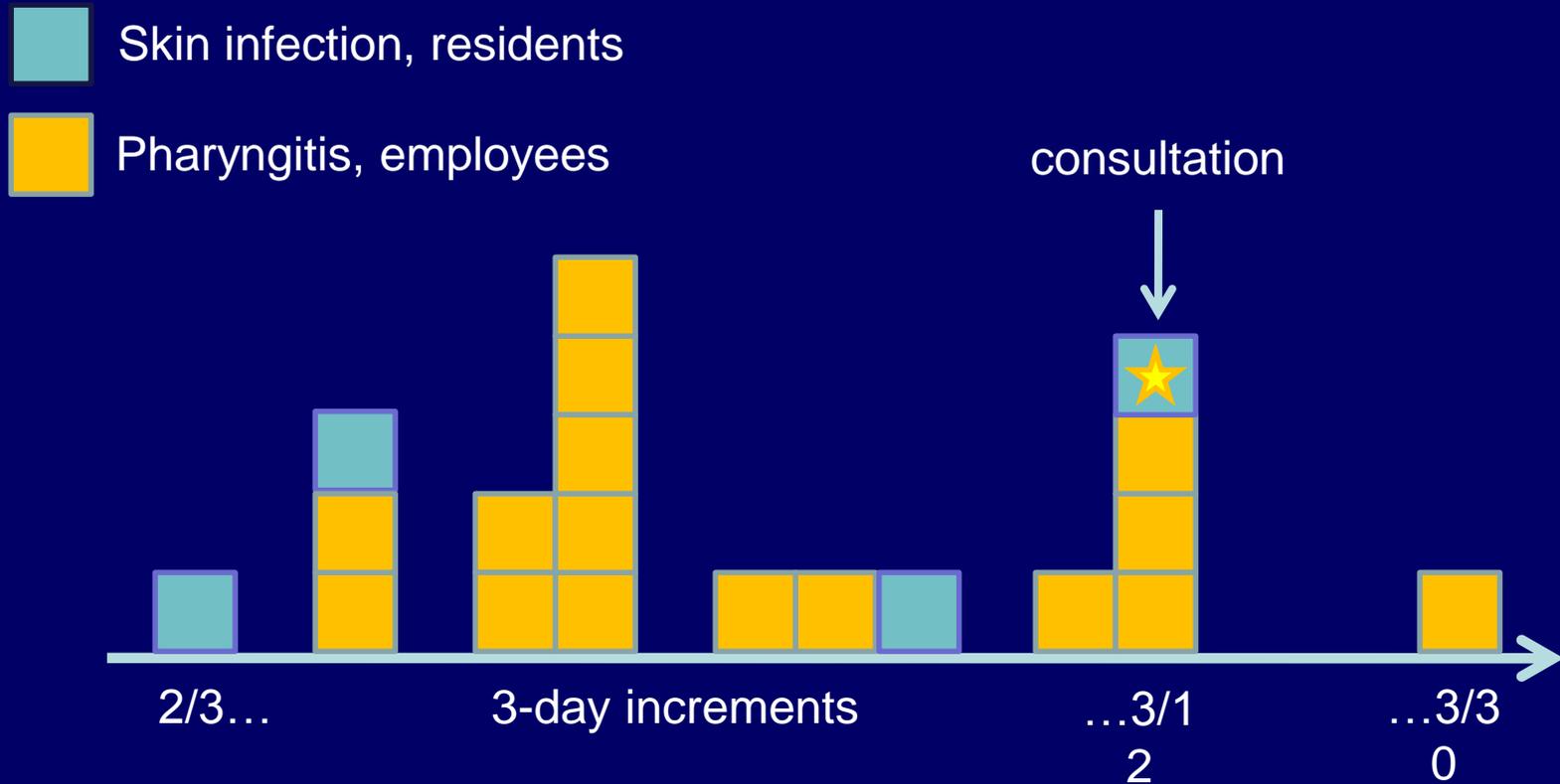
Cellulitis in Memory Care

- 4 residents
- Ecthyma gangrenosum, cellulitis, surgical site infection
- “Strep throat” in staff
- Staff with finger abscess
- Notified public health



Group A Streptococcus

Transmission of Group A Strep in LTCF



Screening & Response

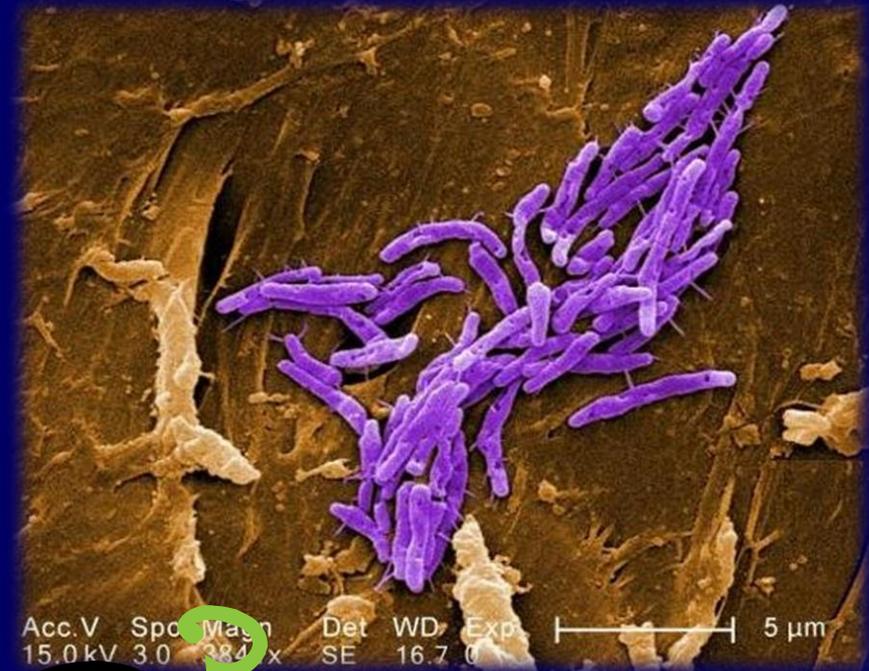
- Facility very collaborative
- Screened 42 of 46 staff, 40 of 41 residents
- 13/42 staff (32%) GAS on culture
- 8/40 residents (20%)
- Pet screening: negative



*GAS colonization usually <5% in adults

Hospital surgical site infections

- Regional meeting of Infection Preventionists
- Report of unusual joint surgical site infections (SSI)
- Rapidly-growing mycobacteria (RGM)
 - *Mycobacterium fortuitum*
- Notified public health



Methods

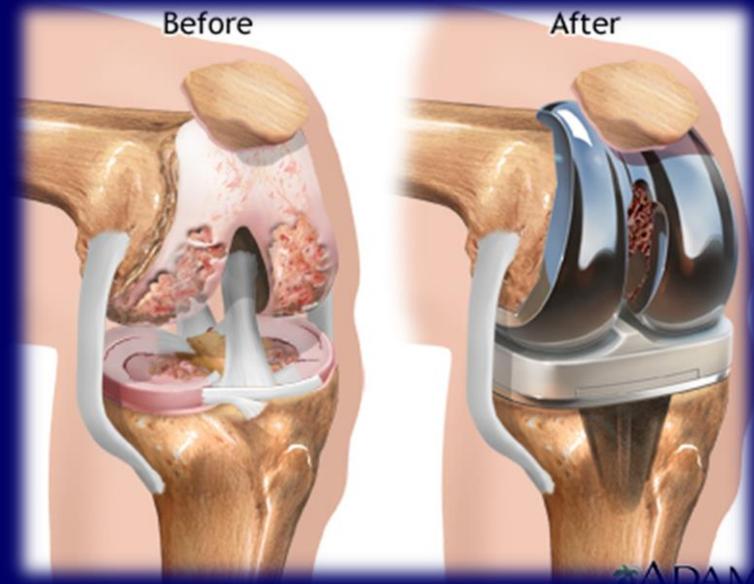
- **Case finding**
 - Surveillance, Health Alert, *Epi-X*
 - National Health Safety Network (NHSN)
 - Surveillance for healthcare-associated infections by healthcare facilities; required for hospitals
- **Matched Case Control Study**
 - Exposures: surgeon, vendor, OR, day, OR staff
- **Observation**
 - Watched 3 joint replacement surgeries
- **Environmental samples**
 - Based on epidemiology

Case Definition

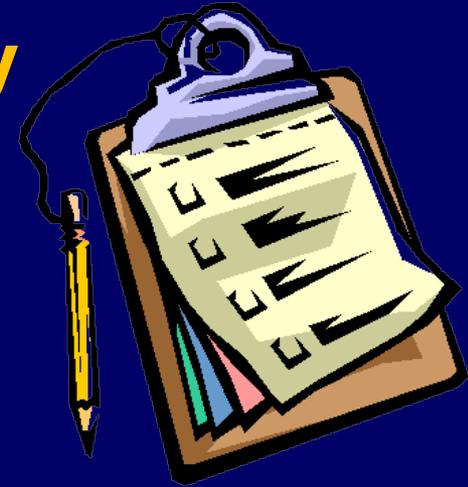
- A surgical site NTM infection involving the skin, tissue, bone or joint
- Between July–December, 2013, or October–November, 2010
- In a patient who underwent knee or hip joint replacement surgery
- At Hospitals A, B, C, or D, within 1 year prior to the infection

Patient Summary

- 7 *M. fortuitum* and 2 *M. goodii*
- Onset October 2010–September 2014
- Aged 46–79 years (median 66 years)
- 5 female
- No trauma
- Different water systems
- Different intra-operative meds
- Deep incision, organ space SSI
- **Significant morbidity**



New School: Case Control Study



- Matched case-control
 - Matched on hospital, type of surgery
 - Same time period
 - 9 cases, 36 randomly selected controls
 - OR staff, time of surgery, age, device manufacturer, orthopedic practice...
- Person A's presence in operating room associated with a **24 times increased odds** of infection in the patient

Person A Interview

- Vendor for manufacturer
- Used hot tub daily before work
- Some devices delivered to home
- Implant and loaner instrument storage in garage and car trunk (not unusual)
- Environmental testing



Operating Room Observations

- Frequent breaches by non-OR staff persons
- Vendor reps witnessed reaching with bare arms over surgical table to indicate instruments
 - Stood <1 foot to surgical table during pre-op prep



Who is on your team?

- Vendor reps an integral part
- Accountability for role in SSIs?
 - Share SSI data
 - Infection prevention training
 - Responsible for maintaining instruments outside OR
- Loaner instrumentation safety issues
 - Shared gaps with FDA



Remediation

- Hold non-hospital operating room staff to same standards

Association of peri-Operative Registered Nurses (AORN)

- Aseptic Practice
 - Patient Safety
 - Sterilization and Decontamination
 - Guidelines for Device Manufacturer Representatives
- Maintain hot tub and regular monitoring of chlorination
 - Implants returned to vendor







DETECT & RESPOND

How do I know I have a problem?



- **EDUCATE:** Syndromes & communication
- **ASK:** Daily huddles with care staff:
 - Clusters of syndromic illness (flu, vomiting/diarrhea)
 - Clusters of NHSN-reportable HAIs (e.g., surgical site infections)
 - Emerging syndromes (e.g., duodenoscope-associated)
- **LOOK:**
 - Assess patient; confirm meets infection criteria
 - Collect and review laboratory results
 - Review medical charts for common risks or exposures

What if I notice a cluster?

- **Reach out** to your local health department
 - www.healthoregon.org/diseasereporting
- **Gather information: Line List**
 - Name, DOB, room (all ill, whether or not lab confirmed)
 - Dates of onset of illness
 - Key symptoms (fever, V, D, rash, pneumonia, cellulitis)
 - Outcomes
 - Vaccination status
- **Tools** available here:
 - <https://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/Outbreaks/Pages/index.aspx>



Healthcare-Associated Infections (HAI)

- Learn about HAIs
- For Health Care Facilities
- For Health Professionals
- For the Public
- HAI Reporting**
- HAI Surveillance
- HAI Validation
- HAI Prevention
- HAI Publications and Maps
- Infection Control Resources

Public Health > Diseases and Conditions > Communicable Disease > Healthcare-Associated Infections (HAI) > HAI Reporting > Healthcare-Associated Infection Outbreaks



Healthcare-Associated Infection Outbreaks

Guidelines for investigating HAI outbreaks, including multidrug-resistant organisms (MDRO)

On this page:

- Mandatory Outbreak Reporting
- Basic Definitions
- Control Measures
- Data Collection and Basic Descriptive Epidemiology
- Data
- Educational Resources
- Resource Links

www.healthoregon.org/hai

Related Resources

- Diseases A-Z
- Emerging Infections
- CDC's HAI website
- National Healthcare Safety Network (NHSN)
- HAI Definitions (pdf)

Contact Us

- HAI Staff Directory
- Acute & Communicable Disease Prevention Section



Mandatory Outbreak Reporting

Acute care hospitals and long-term care facilities (LTCFs) are required to report to the local health authority under OAR 333-018-0000 any healthcare-associated infections (HAI), including by multidrug-resistant organisms (MDRO), that meet the following threshold: "any known or suspected common-source outbreaks; any uncommon illness of potential public health significance" (OAR 333-018-0015; ORS 433.004). Local health authorities are empowered to investigate such outbreaks under OAR 333-019-0000, ORS 433.006.

Carbapenem-resistant *Enterobacteriaceae* is a reportable disease (OAR 333-018-0015; ORS 433.004).

Local health authorities need to report HAI outbreaks, including MDRO outbreaks, to the state communicable disease epidemiology program at 971-673-1111 within 24 hours of receiving an outbreak report.

Data Collection and Basic Descriptive Epidemiology

- Track cases using the [Healthcare Associated Infection Case Log \(pdf\)](#). The log can be completed by hospital or LTCF infection control staff; establishing a single point of contact is recommended.
- Use tools to get basic descriptive epidemiology, including an epidemic curve (i.e., cases by onset day).
- Review facility's microbiology laboratory for other cases of the same organism or MDRO within the last 12 months. If found, perform a limited chart review and note name, date of birth, source, room number, admission source, healthcare facility exposures.
- Consider performing a [patient prevalence survey](#) to assess burden of the organism or MDRO in healthcare facility. Refer to the [Specimen Collection Protocol \(pdf\)](#).
- Monitor the outbreak for new cases for 6 months.
- If ongoing transmission is identified, discuss performing further investigations (e.g., [environmental prevalence survey](#))

Response

- Review case medical records for risk factors
- Environmental cleaning
 - [High-touch Cleaning Checklist \(pdf\)](#)
 - [CDC Environmental Checklist for Monitoring Terminal Cleaning \(pdf\)](#)
- Interfacility transfer forms: Find forms and resources at [Interfacility Communication](#)
- Patient prevalence survey
 - Tools: [Patient letter \(pdf\)](#), [Staff letter \(pdf\)](#)
- Staff Education: [Person Protective Equipment \(PPE\) Protocol \(pdf\)](#)
- Patient Education:
 - [10 Ways to be a Safe Patient \(pdf\)](#)
 - [MDR Ab Patient Education \(pdf\)](#)
 - [CRE Patient Education: Oregon CRE Toolkit \(pdf\)](#)
 - [Provider CRE Notification Letter \(pdf\)](#)
 - [Prevention: CDC Detect/Protect \(pdf\)](#)

What happens if I report a cluster?

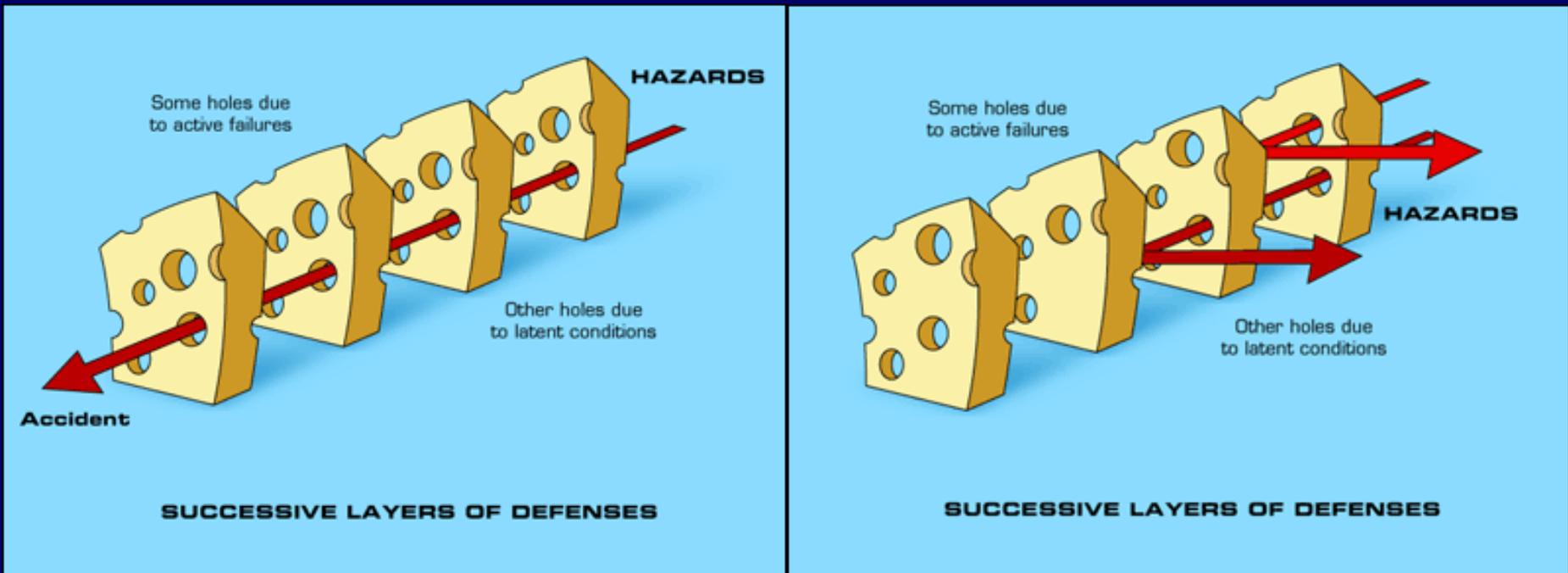
- Local public health coordinates with facility staff:
 - Gather info
 - Identify pathogen
 - Form a plan to halt outbreak
 - Determine source
- Public health may contact other facilities
- Residents/Patients are usually not contacted
- Public health may ask to review resident's charts
- Follow-up to ensure plan completed, outstanding issues

Outbreak expectations

- **Facilities and providers will work collaboratively with PH**
 - Make timely reports to public health*
 - Share information
 - Discuss recommendations
- **Public health will work collaboratively with facilities and providers to contain the outbreak and identify a source:**
 - Special lab testing
 - Protect personal health information
 - Work with providers to ensure patient safety
 - Educate facilities and providers, as indicated

What's the benefit of reporting a cluster?

- Prevent other residents from becoming ill
- Prevent staff from becoming ill
- Identify the issue and improve the system



Examples of response in action

- **Ambulatory surgery center mycobacterial surgical site infections**
 - On-site infection prevention consultation improved practice safety
- **Hepatitis associated with medical care**
 - Reviewed outpatient practice, and notified >1200 Oregonians
 - Reviewed dialysis center practice; provided strain type testing
- **Influenza/Respiratory disease**
 - Local health department helps identify contacts for prophylaxis, decreasing morbidity and death
 - Local health departments assisted 59 facilities during 2015
- **Norovirus/Gastrointestinal disease**
 - Assisted 81 facilities during 2015

Examples of response in action

- Carbapenem-resistant *Acinetobacter baumannii*
 - Identification led to trace-back to super-spreader patient and establishment of interfacility transfer communication process

One fine day at ACDP...

- Infection prevention control nurse, Hospital A
 - 2 isolates of *Acinetobacter baumannii*
 - 2 months apart
 - 2 patients from same Skilled Nursing Facility A
- Surveillance review identified other cases at Healthcare Facility B



Traceback

Outpatient Clinic A

PICC infusion / ostomy care
and chemo. chem

✗

✗ Foley
incontinent

✗
[Dates] PICC
wand

Patient C

Patient B

Patient A

⊕ 9/26
③ CPC

⊕ 11/22
CPC

⊕ 6/14
①
Leads
PDX

SNF A

9/21 - 9/26

④
9/28 - 9/30
10/12 - 10/15

10/10 - 10/12
10/18 - ?

Hospital A

No

11/24 - NOW
convallis

2/13 - 3/20
5/11 - 17
6/11 - 6/26 (PDX)

Outpatient Clinic A

8/1? - 8/15
dnc OP -
8/16 - 8/31
② 9/26 ED →
dnc CPC NPP
of 7/26

9/20 - 9/28
9/30 - 10/12
11/22, 11/24

① OP wound care:
since 2011
10/12 - 10/17

Health Care Facility B

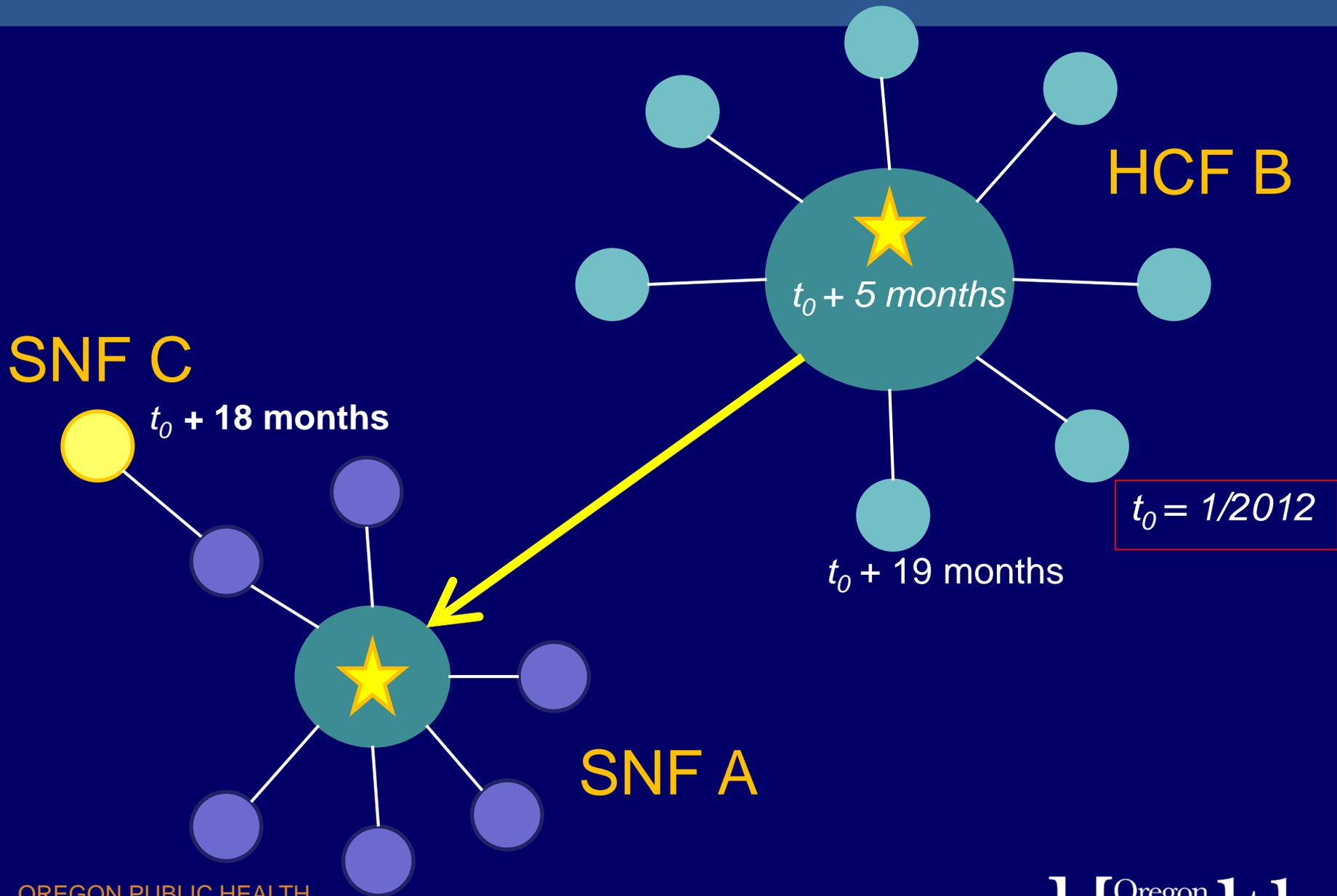
?

?

3/20 - 4/26
5/? - 6/11
6/26 → ?
(PDX to ?
PDX hosp)

LTC

4/26 -



Interfacility transfer communication

- Rule since January 1, 2014
- Healthcare facilities, including
 - Hospitals, birthing centers
 - Dialysis
 - Ambulatory Surgery Centers
 - Nursing homes, CBC
- Report to receiving facility
 - Written, any disease needing precautions (CDI, MDRO...)
- Receiving facility reports back
 - if present on admission

The screenshot shows the Oregon Health Authority website page for "Interfacility Transfer Communication". The page is titled "Interfacility Transfer Communication" and is part of the "Healthcare-Associated Infections (HAI)" section. The main content area is titled "Communication During Patient Transfer of Multidrug-Resistant Organisms (MDRO)" and includes a sub-heading "As part of best practice during patient transfers, information about a patient's medical status, including colonization or infection with a multidrug-resistant organism, should travel with a patient and be readily available to medical providers." Below this, there is a section titled "On this page:" with a list of links: "What does Oregon law require?", "Why are we doing this?", "What should health care facilities do?", "Sample interfacility transfer forms", and "Resources". There is also a section titled "What does Oregon law require?" with a link to a PDF document: "The new rule 'Communication During Patient Transfer of Multidrug-Resistant Organisms' OAR 333-019-0052 (pdf) sets patient safety expectations about timely communication between health care facilities about multidrug-resistant organisms or pathogens that warrant Transmission-based Precautions. Transmission-based Precautions are disease- or syndrome-specific precautions taken in addition to Standard Precautions, based on the disease or syndrome transmission route and exposure risk (e.g., influenza requires droplet; tuberculosis requires airborne; diarrhea requires contact)." The page also features a sidebar with navigation links, a search bar, and social media icons.

Inter-facility Infection Control Transfer Form

SENDING FACILITY TO COMPLETE FORM and COMMUNICATE TO ACCEPTING FACILITY

Please attach copies of latest culture reports with susceptibilities, if available

Patient/Resident Last Name	First Name	Date of Birth
<i>Print or place Patient Label</i>		

Sending Facility Name	Sending Facility Unit	Sending Facility Phone #

Is the patient/resident currently on antibiotics? NO YES **DX:** _____

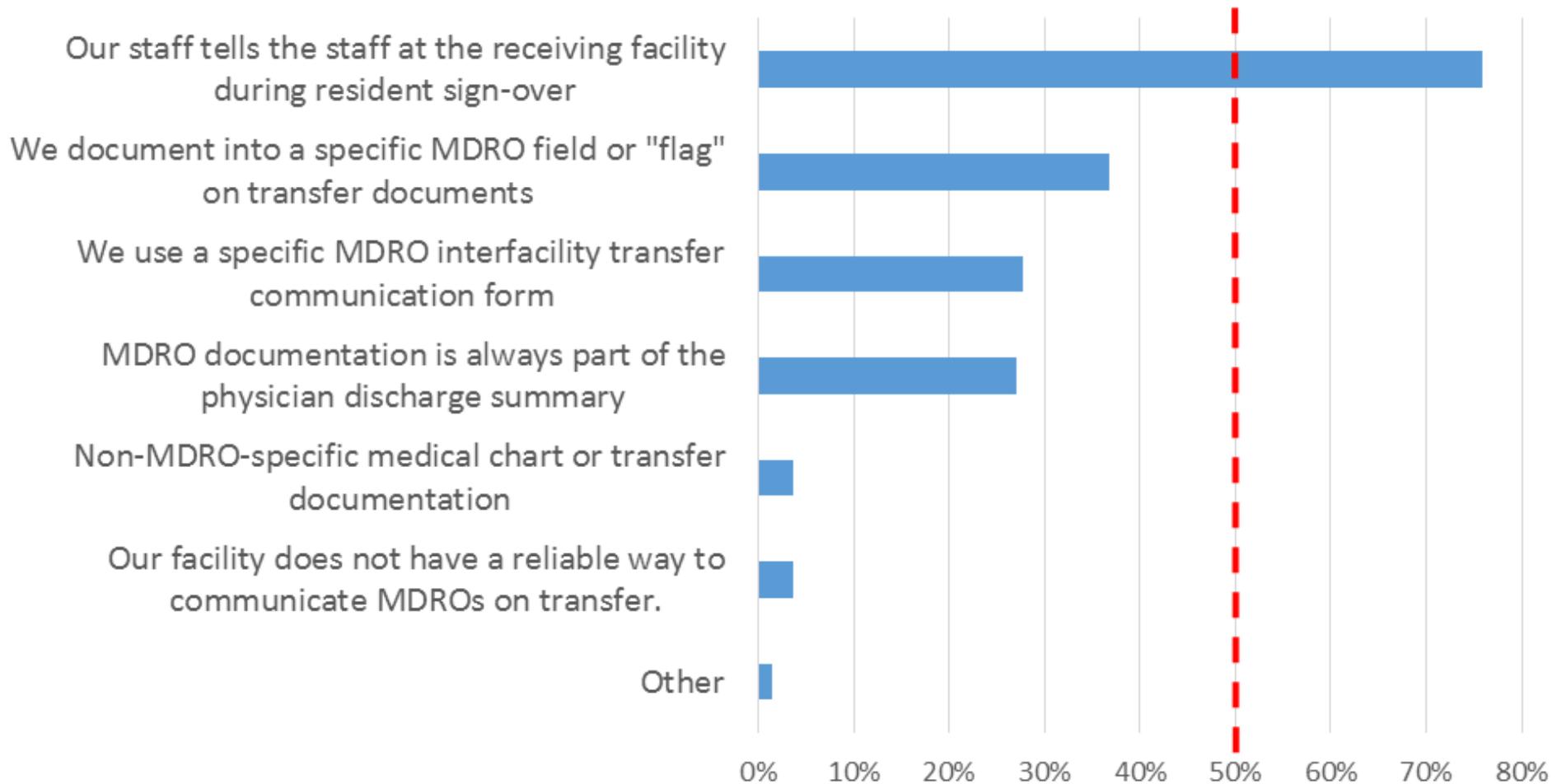
Does the patient/resident have pending cultures? NO YES

Is the patient/resident currently on precautions? NO YES

Type of Precautions (check all that apply) Contact Droplet Airborne Other: _____

Does patient currently have an infection, colonization OR a history of a multidrug-resistant organism (MDRO)?	Colonization or history <i>Check if YES</i>	Active infection on treatment <i>Check if YES</i>
MRSA (methicillin-resistant <i>Staphylococcus aureus</i>)	<input type="checkbox"/>	<input type="checkbox"/>
VRE (Vancomycin-resistant <i>Enterococcus</i>)	<input type="checkbox"/>	<input type="checkbox"/>
<i>C. diff</i> (<i>Clostridium difficile</i> , CDI)	<input type="checkbox"/>	<input type="checkbox"/>
<i>Acinetobacter</i> spp. , multidrug-resistant	<input type="checkbox"/>	<input type="checkbox"/>
Gram-negative organism resistant to multiple antibiotics* (e.g., <i>E. coli</i> , <i>Klebsiella</i> , <i>Proteus</i> spp.)	<input type="checkbox"/>	<input type="checkbox"/>
CRE (carbapenem-resistant <i>Enterobacteriaceae</i>)	<input type="checkbox"/>	<input type="checkbox"/>

How does your facility communicate MDRO or CDI at transfer? (N = 133)



Implementation

- 121 of 133 (91%) reported sending an interfacility transfer form
- 70 of 133 (53%) reported receiving a form
- *Review your interfacility transfer form and process:*
 - Verbal is insufficient
 - Can't be buried in discharge planning EPIC screens
 - Golden Rule

What can I do to improve response?

- Get to know the **infection preventionists** at your referring hospitals
 - They want to know you!
 - Great resources and pulse of what's going on in region
 - Interfacility communication of infectious diseases
- Get to know your **public health partners**
 - www.healthoregon.org/diseasereporting
- Know your **policies and procedures** for dealing with infectious diseases
 - e.g., Guidelines for Minimum Expectations in Outpatient Clinics

RESOURCES



Resources provided by public health

- Advanced testing
- Advanced epidemiology and analysis
- Consultation with subject matter experts
- Correct reporting to other agencies (e.g., Medwatch)
- Connection with other facilities
- Second pair of eyes
- ...
- Lab Risk Assessment template!



<http://oregonpatientsafety.org/>

Oregon Patient Safety Commission On-Site Consultations 2016–2017

The screenshot shows the CDC website page for "Infection Control Assessment Tools". The page is titled "Healthcare-associated Infections (HAIs)" and "Infection Control Assessment Tools". It features a navigation menu on the left, a search bar at the top right, and a "Print page" button. The main content area includes a description of the tools, a list of tools with PDF download links, and a "Contact Us" section. The left navigation menu includes "Healthcare-associated Infections", "Data and Statistics", "Types of Infections", "Diseases and Organisms", "Preventing HAIs", "Targeted Assessment for Prevention (TAP)", "State Policy Resources", "ELC Activities", "Guidelines and Recommendations", "Toolkits", "Basic Infection Control and Prevention Plan for Outpatient Oncology Settings", "Outpatient Care Guide", "Tools for Protecting Healthcare Personnel", "Infection Control Assessment Tools", "CDC HAI Commentaries", "Map: HAI Prevention Activities", "Research", and "Patient Safety".

Home
Centers for Disease Control and Prevention
CDC 24/7: Saving Lives. Protecting People.™

SEARCH

A-Z Index A B C D E F G H I J K L M N O P Q R S T U V W X Y Z #

Healthcare-associated Infections (HAIs)

Healthcare-associated Infections > Preventing HAIs

Print page

Get email updates
To receive email updates about this page, enter your email address:

What's this? Submit

Infection Control Assessment Tools

The basic elements of an infection prevention program are designed to prevent the spread of infection in healthcare settings. When these elements are present and practiced consistently, the risk of infection among patients and healthcare personnel is reduced.

The Infection Control Assessment Tools were developed by CDC for awardees under the [Epidemiology and Laboratory Capacity \(ELC\) Infection Control Assessment and Response \(ICAR\) Program](#) to assist health departments in assessing infection prevention practices and guide quality improvement activities (e.g., by addressing identified gaps). These tools may also be used by healthcare facilities to conduct internal quality improvement audits.

Assessment tools were developed for the following healthcare settings: acute care (including hospitals and long-term acute care hospitals), outpatient, long-term care, and hemodialysis. Select the assessment tool below that is specific to your setting.

- Infection Control Assessment Tool for Acute Care Hospitals [PDF - 433 KB]
- Infection Control Assessment Tool for Long-term Care Facilities [PDF - 253 KB]
- Infection Control Assessment Tool for Outpatient Settings [PDF - 337 KB]
- Infection Control Assessment Tool for Hemodialysis Facilities [PDF - 278 KB]

NOTE: For Outpatient settings, the previously released *Guide to Infection Prevention for Outpatient Settings and its companion Checklist* (available at: <http://www.cdc.gov/HAI/settings/outpatient/outpatient-care-guidelines.html>) have been revised and made consistent with the *Outpatient Settings Infection Control Assessment Tool*. While the same infection prevention elements are included in both the checklist and assessment tool, the facility demographics sections differ slightly. The assessment tool is intended for health department use to complete ELC activities whereas the [checklist](#) is intended primarily for healthcare facility use.

Contact Us:
Centers for Disease Control and Prevention
1600 Clifton Rd
Atlanta, GA 30333
800-CDC-INFO (800-232-4636)
TTY: (888) 232-6348
[Contact CDC-INFO](#)

OR
Acute
Patient Safety

Infection Control Self-Assessment Tools

VIII. Injection Safety and Point of Care Testing		
Elements to be assessed	Assessment	Notes/Areas for Improvement
A. The facility has a policy on injection safety which includes protocols for performing finger sticks and point of care testing (e.g., assisted blood glucose monitoring, or AMBG).	<input type="radio"/> Yes <input type="radio"/> No	
B. Personnel who perform point of care testing (e.g., AMBG) receive training and competency validation on injection safety procedures at time of employment. <i>Note: If point of care tests are performed by contract personnel, facility should verify that training is provided by contracting company</i>	<input type="radio"/> Yes <input type="radio"/> No	
C. Personnel who perform point of care testing (e.g., AMBG) receive training and competency validation on injection safety procedures within the past 12 months. <i>Note: If point of care tests are performed by contract personnel, facility should verify that training is provided by contracting company</i>	<input type="radio"/> Yes <input type="radio"/> No	

EDUCATION



Educational opportunities

The screenshot shows the website's navigation bar with the following items: About the Campaign, Safe Injection Practices, Healthcare Provider Information, Patient Information, Campaign Resources (highlighted with a red circle), News, and Contact Us. The 'Campaign Resources' dropdown menu is open, listing: Print Materials, Audio & Video, Toolkits, Social Media, and Buttons & Images.

Bloodborne Pathogens Training

1 ONE NEEDLE, ONE SYRINGE, ONLY ONE TIME.
Safe Injection Practices Coalition
www.ONEandONLYcampaign.org

Safe Injection Practices: Protecting Yourself and Your Patients

A Bloodborne Pathogens Training Activity

remind
asures they
bloodborne
pathogens and other injection exposures, as
required by the Occupational Safety and Health
Administration (OSHA), also protect patients
from healthcare associated infections. Injection
safety and other basic infection prevention and
control practices are central to patient and
healthcare provider safety.

*This training activity is supplemental to the
required annual bloodborne pathogens training
for healthcare personnel.*

**DO YOUR PART TO MAKE HEALTHCARE SAFE,
ONE INJECTION
AT A TIME.**
Order FREE
Materials!

1 ONE NEEDLE, ONE SYRINGE, ONLY ONE TIME.
Safe Injection Practices Coalition
www.ONEandONLYcampaign.org

OREGON [View Training](#) | [View Text Transcript](#)

Acute & [Download](#) the latest version of Flash to view this training.
(Thank you for your patience as this training downloads)

Course & Webinars

- Infection Control Fundamentals Course

- November, 1–3, 2016
- FREE, open to all
- <http://oregonpatientsafety.org/news-events/past-events/knowledge-share-webinar-series/696/>
(includes other webinars)

- HAI Webinars: Lunch & Learn

- 3rd Wednesday of the month, lunchtime
- Open to all providers, LHDs, labs, etc.
- <https://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/HAI/Prevention/Pages/Lunch-and-Learn.aspx>

Thank you for your collaboration to
improve care for Oregonians!

Acute & Communicable Disease Prevention Team

HAI Team

(971) 673-1111 (24/7)

Ohd.acdp@state.or.us

