Lessons Learned from Group A *Streptococcus* Investigations

2026 Nebraska Infectious Diseases Conference

Claire Ortlieb, MPH | HAI Epidemiologist

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DIVISION OF PUBLIC HEALTH

Disclosures

I have no conflicts of interest or financial relationships to disclose.

Objectives

- ❑ Define an invasive Group A Strep infection.
- ❑ Describe transmission routes of Group A Strep.
- ❑ Recognize an outbreak of Group A Strep infections.
- ❑ Identify Group A Strep outbreak resources for prevention and control.

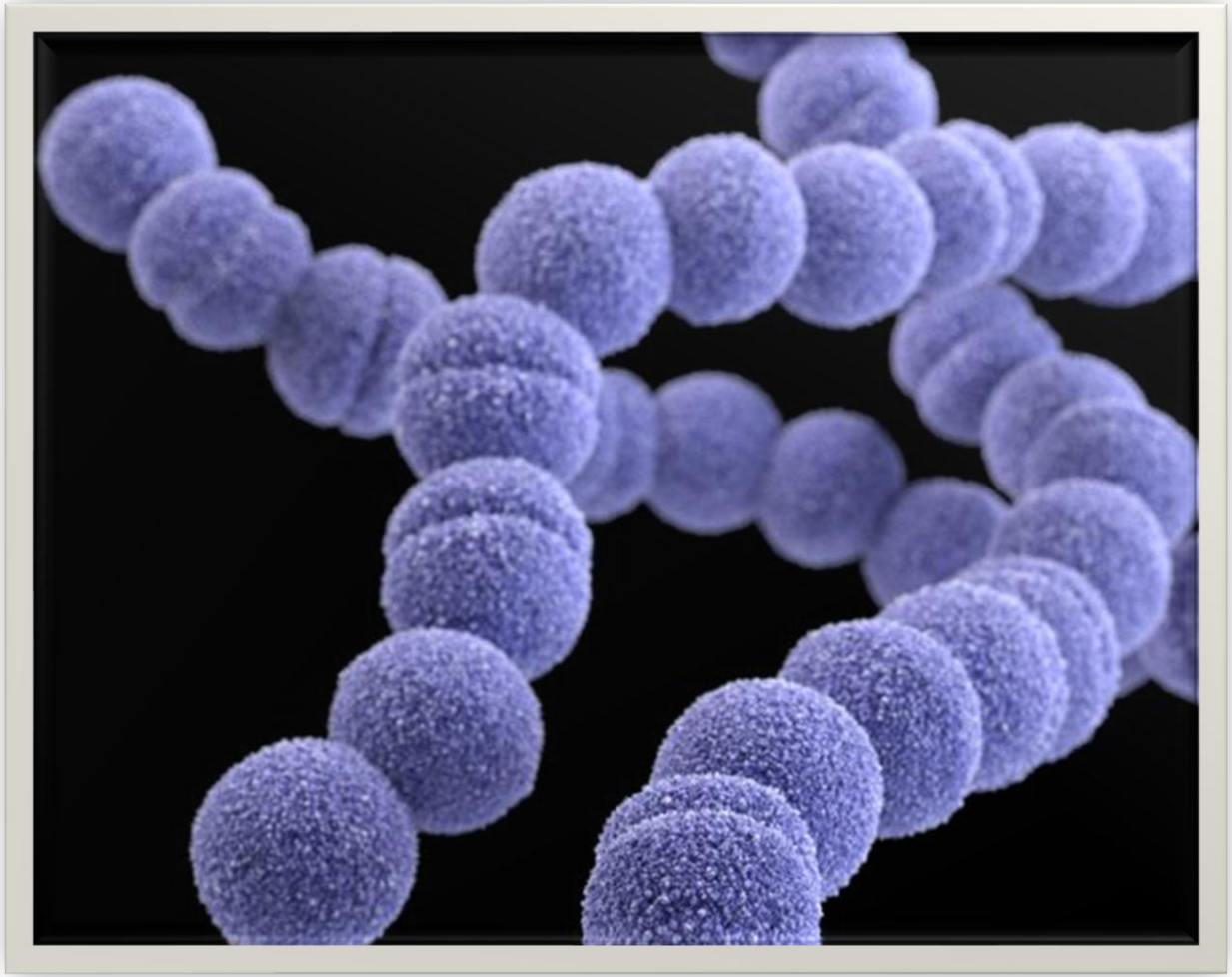
Abbreviations

- **GAS** – Group A Streptococcus
- **iGAS** – Invasive Group A Streptococcus
- **HAI** – Healthcare associated infection
- **LTCF** – Long term care facility

Background

What is Group A *Streptococcus*?

- Group A Streptococcus, or *Streptococcus pyogenes*, is a gram-positive cocci that typically grows in chains or pairs
- GAS is responsible for a wide-range of mild to life-threatening infections in humans



Source: https://www.cdc.gov/group-a-strep/about/index.html

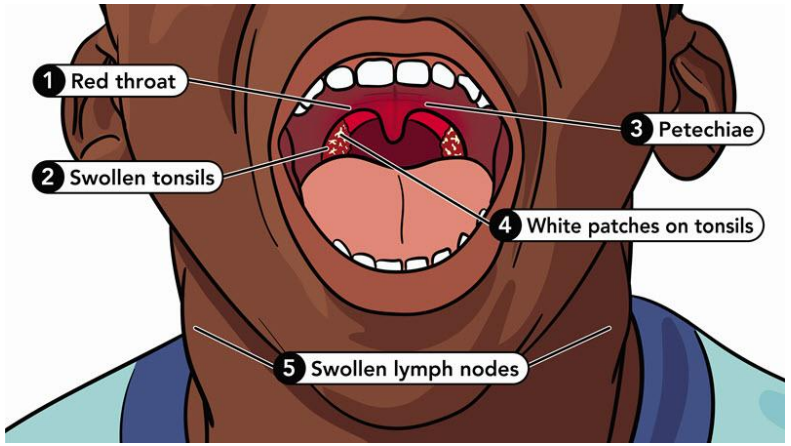
Group A *Streptococcus* Infections

- GAS infections can range from minor to serious

Minor Infections
- Impetigo
- Strep throat

Serious Infections
- Cellulitis
- Necrotizing fasciitis
- Sepsis
- Streptococcal toxic shock syndrome (STSS)

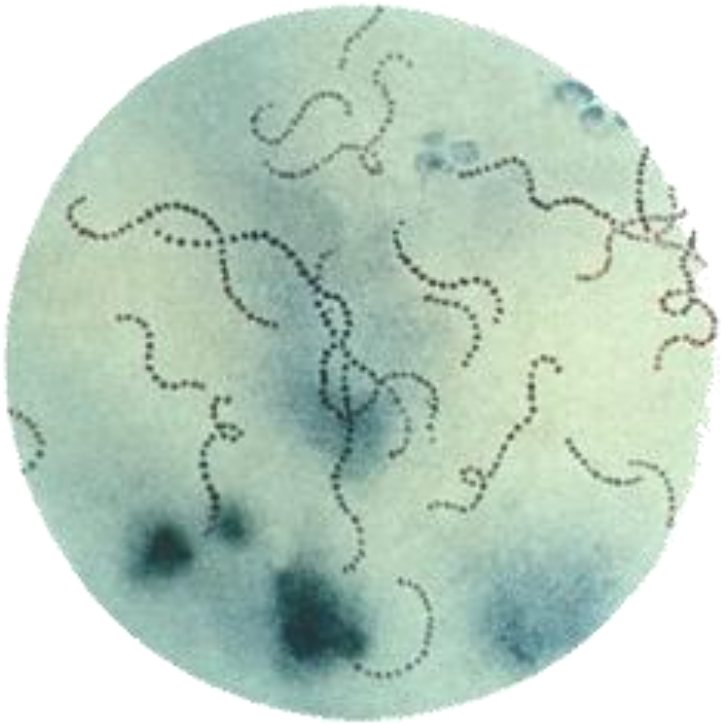
- Serious GAS infections can also cause long-term health issues



Source: https://www.cdc.gov/group-a-strep/about/index.html

Invasive Group A *Streptococcus* Infections

- Invasive Group A *Streptococcus* is a severe, potentially life-threatening infection that requires emergency medical care.
- iGAS infections occur when *Streptococcus pyogenes* bacteria infect normally sterile body sites like the blood, cerebrospinal fluid, or deep tissues.



https://apic.org/emerging-infectious-diseases/invasive-group-a-strep-igas/

Risk Factors for Serious Infections

Viral infections

Pre-existing medical conditions:

- Cancer
- Chronic heart, kidney, liver, lung disease
- Diabetes
- Immunocompromising conditions
- Obesity

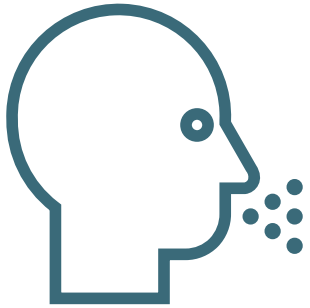
People 65 years and older

People who inject drugs or who are experiencing homelessness

Residents of LTCFs

Source: https://www.cdc.gov/group-a-strep/about/index.html

How it Spreads



Respiratory Droplets

Direct Contact

 Source: https://www.cdc.gov/group-a-strep/about/index.html

Incubation Period

Strep Throat

- 2-5 days after exposure, rarely longer

Invasive Group A Strep

- Variable, but typically 1-5 days
  - May be as short as 14 hours in some cases of Streptococcal Toxic Shock Syndrome (STSS).
- Postpartum and postsurgical invasive GAS infections usually present within 7 days.

Source: https://www.cdc.gov/group-a-strep/about/strep-throat.html

Infectious Period

Individuals with GAS are most contagious when they are first symptomatic.

In individuals who are not treated with antibiotics, they are infectious for about 1 week.

Individuals who are treated with antibiotics are no longer contagious after 24 hours of taking the antibiotic.

Asymptomatic carriers of GAS have low risk of transmission to others, but not zero.

Untreated infected open sores or wounds may be infectious for weeks or months.

Testing & Treatment

- Strep throat
  - Rapid Antigen Detection Test (RADT)
  - Throat Culture (gold standard diagnostic test)
  - Penicillin or amoxicillin is the antibiotic of choice
- Invasive GAS
  - Culture (blood, tissue, etc.)
  - Antibiotic treatment can vary based on severity of disease:
    - Oral antibiotics: Cephalosporins, Clindamycin, Dicloxacillin, Penicillin
    - IV antibiotics: Cefazolin, Ceftriaxone, Clindamycin, Penicillin

Source: https://www.cdc.gov/group-a-strep/about/strep-throat.html

Preventing GAS Infections

- Prevention of GAS infections can vary by disease, but in general, prevention includes:
  - Limitation of exposure and spread of bacteria
  - Treatment of GAS infections promptly

Source: https://www.cdc.gov/group-a-strep/about/index.html

Group A *Streptococcus* Surveillance and Trends

Active Bacterial Core Surveillance (ABCs) Report
Emerging Infections Program Network
Group A *Streptococcus*, 2024

ABCs Areas: California (3 county San Francisco Bay area); Colorado (5 county Denver area); Connecticut; Georgia (20 county Atlanta area); Maryland (6 county Baltimore area); Minnesota; New Mexico; New York (15 county Rochester and Albany areas); Oregon (3 county Portland area); Tennessee (20 urban counties).

ABCs Population: The surveillance areas represent 35,583,503 persons. Source: Census Bureau's Vintage 2024 population estimates.

ABCs Case Definition: Invasive bacterial disease is defined as isolation of group A *Streptococcus* from a normally sterile site or from a wound culture accompanied by necrotizing fasciitis or streptococcal toxic shock syndrome or detection of ABCs pathogen-specific nucleic acid in a specimen obtained from a normally sterile site, using a validated molecular test in a resident of one of the surveillance areas.

ABCs Methodology: ABCs personnel routinely contacted all microbiology laboratories serving acute care hospitals to identify cases. Standardized case report forms including demographic and clinical characteristics were completed for each case. All group A *Streptococcus* (GAS) isolates were subject to whole genome sequencing (WGS) to derive *emm* types and to predict minimum inhibitory concentration (MIC). Regular laboratory audits assessed active surveillance completeness.
Rates were calculated using population estimates from the Vintage 2024 file. For national estimates of cases, race and age specific rates of disease were applied from the aggregate surveillance area to the age and racial distribution of the U.S. population. Cases with missing data, excluding ethnicity, were multiply imputed using sequential regression imputation methods.¶

ABCs Profiles

Race	No.	Rate*	Ethnicity	No.	Rate*
Black	701	11.7	Hispanic	630	11.1
White	3,238	13.0	Non-Hispanic	3,384	-
Other	392	8.2	Unknown	317	-

	Cases		Deaths	
Age (years)	No.	Rate*	No.	Rate*
<1	31	8.3	3	0.81
1	23	6.0	0	0.00
2-4	54	4.7	1	0.09
5-17	189	3.4	5	0.09
18-34	486	6.0	25	0.31
35-49	904	12.5	50	0.69
50-64	1,078	16.5	91	1.39
65-74	753	21.1	94	2.64
75-84	517	27.1	82	4.30
≥85	296	46.6	65	10.22
Total	4,331	12.2	416	1.17

*Rates are per 100,000 population for ABCs areas

National Estimates of Invasive Disease

Total Cases: 41,400 (12.2/100,000 population)
Deaths: 3,980 (1.17/100,000 population)

¶ Surveillance Note

Missing race (n=476) data were multiply imputed using sequential regression imputation methods.

Emm Types

Area	Most Common emm Types**	% Area Isolates
Total	1,44,3,49,92,77	50.7
CA	1,12,77,53,44	66.9
CO	44,11,1,53,82	54.6
CT	1,49,89,83,3,92	72.1
GA	3,1,89,4	60.1
MD	49,1,92,3	65.4
MN	44,49,3,1,28,89,12	68.8
NM	1,77,53,101,44,91,59	70.5
NY	1,75,11,3,59	56.5
OR	44,1,76,92	60.3
TN	82,151,1,3,89,11,4,92	75.3

**Requires ≥3 isolates and ≥5% of isolates typed by area. Based on reference lab testing of 3739 isolates.

Syndromes

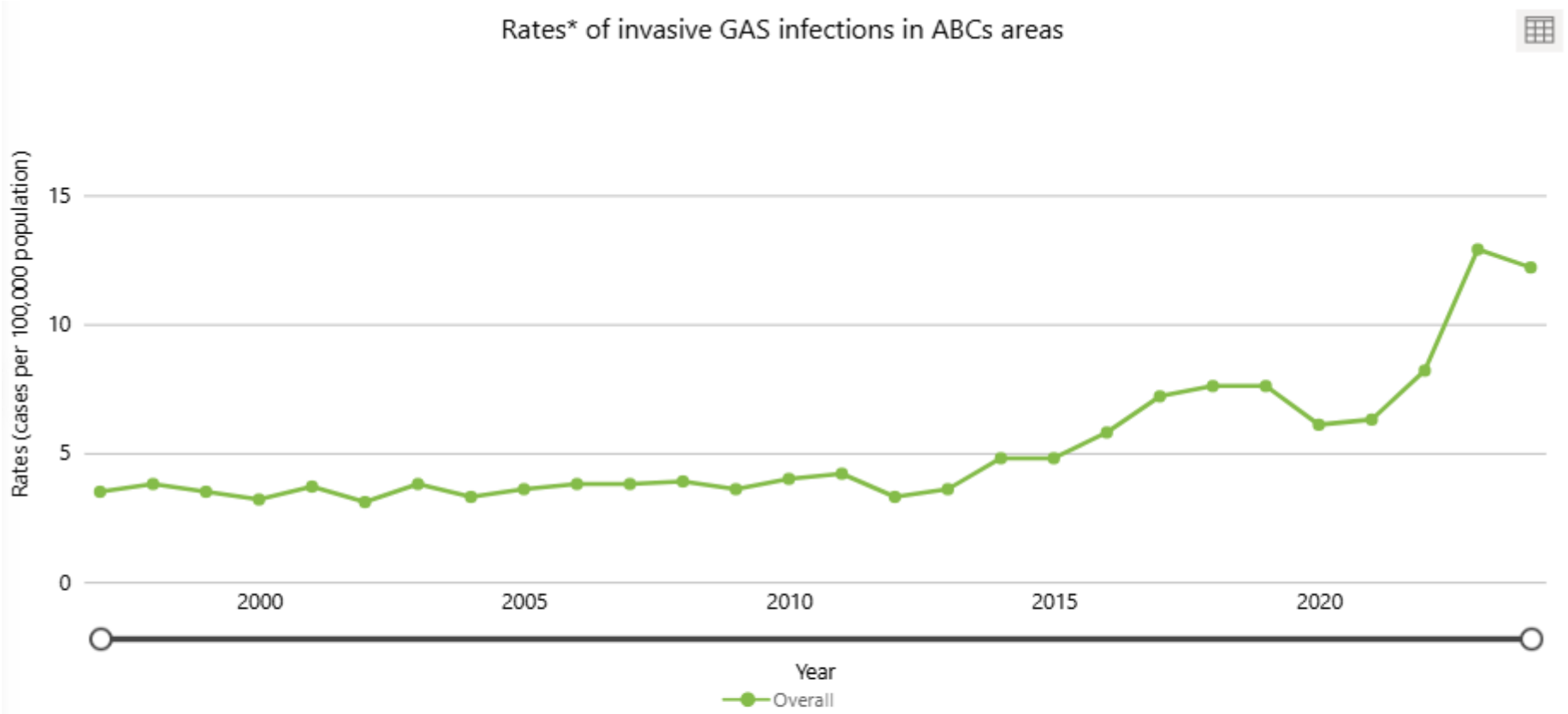
Syndrome	No.	%
Cellulitis	1,992	46.0
Pneumonia	661	15.3
Bacteremia without focus	628	14.5
Necrotizing fasciitis	269	6.2
Streptococcal toxic shock syndrome	143	3.3

Note: Some cases had more than 1 syndrome.

Citation

Centers for Disease Control and Prevention. 2024. Active Bacterial Core Surveillance Report, Emerging Infections Program Network, Group A Streptococcus, 2024.
www.cdc.gov/abcs/downloads/GAS_Surveillance_Report_2024.pdf

Recent Trends



*Rates are calculated as cases per 100,000 population.

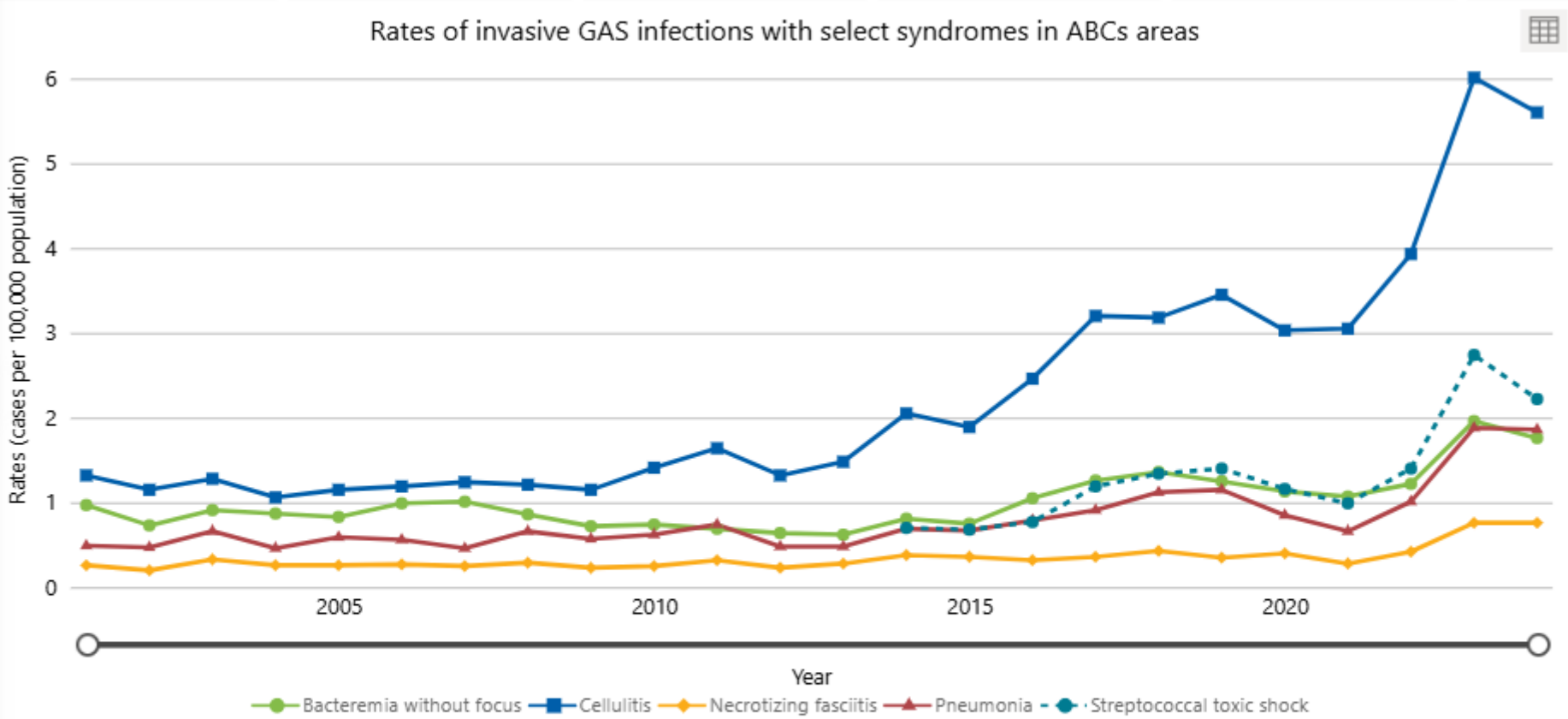
**Prior to 2021, bridged race categories were used to report rates by race. Beginning in 2021, rates are reported using unbridged race categories. Read more about race bridging.

Note

- Methods, such as the way missing data are taken into account, have changed over time. ABCs reports describe the specific methodology used for each year by bacterium.
- Surveillance areas have changed over time.

 Source: https://www.cdc.gov/abcs/bact-facts/data-dashboard.html

Recent Trends

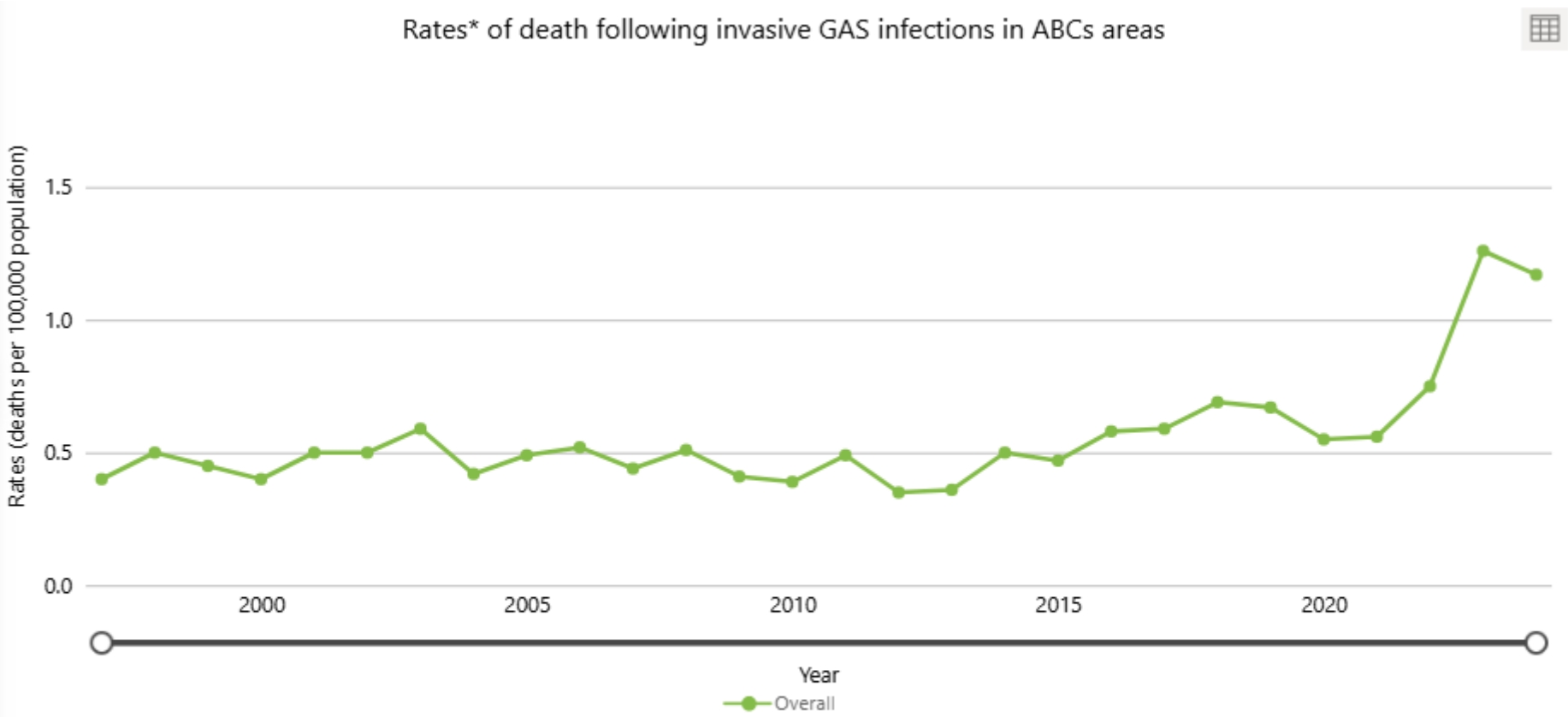


Note

- Cases might have more than one syndrome (e.g., a case with both pneumonia and meningitis in the same individual) and are included in calculations for each syndrome. Information on how syndromes are defined can be found under the Methodology section.
- Bacteremia without focus cases are those in persons who had a positive blood culture but no other clinical syndrome identified (e.g., pneumonia or meningitis).
- Streptococcal toxic shock syndrome (STSS) defined using the clinical case definition from the Council of State and Territorial Epidemiologists (CSTE). Connecticut was excluded from STSS rate calculations in 2023 and 2024.
- Methods, such as the way missing data are taken into account, have changed over time. ABCs reports describe the specific methodology used for each year by bacterium.
- Surveillance areas have changed over time.

Source: https://www.cdc.gov/abcs/bact-facts/data-dashboard.html

Recent Trends



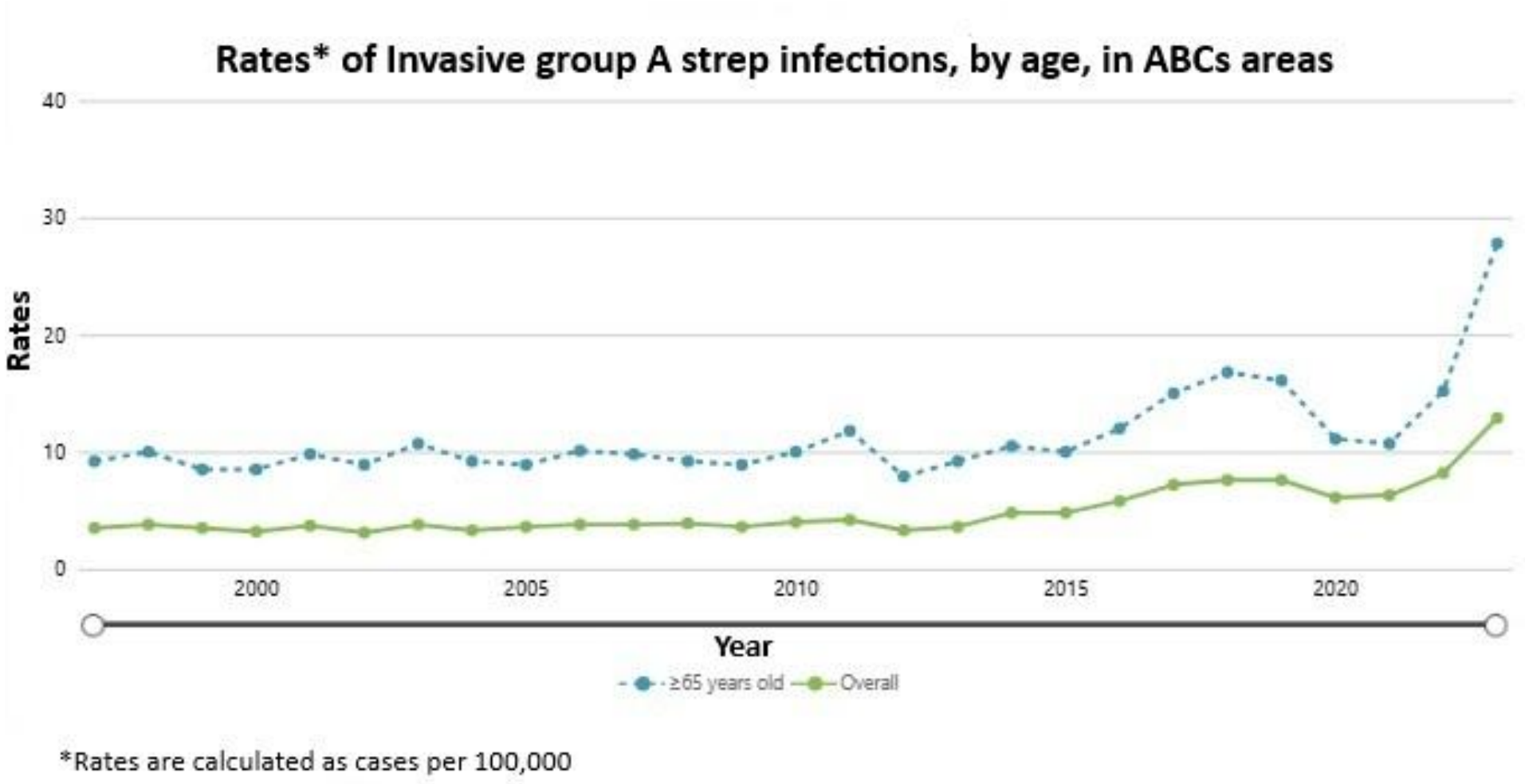
*Rates of death are calculated as deaths per 100,000 population.

Note

- Methods, such as the way missing data are taken into account, have changed over time. ABCs reports describe the specific methodology used for each year by bacterium.
- Surveillance areas have changed over time.

 Source: https://www.cdc.gov/abcs/bact-facts/data-dashboard.html

Recent Trends



 Source: https://www.cdc.gov/group-a-strep/php/surveillance/index.html

Invasive Group A Strep in Nebraska

Year	Invasive GAS Cases	HAI Invasive GAS Cases	LTCF-related Cases
2025	120	28	18
2026 to date	71	9	6

Source: Numbers provided by Nebraska Electronic Disease Surveillance System (NEDSS)

Outbreak Investigations

Group A Strep Outbreak Investigations

A single case of invasive group A strep in a resident at a LTCF will trigger an investigation. Why?

Identify any additional symptomatic cases among residents and staff

Identify and treat asymptomatic carriers

Assess and improve current infection control practices in the facility

Identify potential transmission routes

Source: https://www.cdc.gov/group-a-strep/php/ltcf-toolkit/

Identify additional symptomatic cases

Search

- Conduct a retrospective chart review of facility residents over previous month. Review records at LTCF, referral hospitals, and referral laboratories.
- Survey all current residents and healthcare personnel (HCP), including consultants, for symptoms of GAS infection.
- Culture symptomatic residents and HCP as clinically indicated.

Treat

Treat residents and HCP as clinically indicated. Review the page on **antibiotic regimens** for detailed guidance.

Investigation Tools

CDC Decision Tool for Investigating Group A *Streptococcus* Infections in Long-term Care Facilities

KEY POINTS

- CDC has tools to address investigating and controlling group A *Streptococcus* (GAS) infections and outbreaks in long-term care facilities (LTCF).
- LTCF staff should work with their local public health departments when investigating suspected GAS outbreaks.
- View or download the toolkit for detailed information and recommended antibiotic regimens.

TABLE OF CONTENTS | DECISION TOOL FOR INVESTIGATING GAS INFECTIONS IN LTCFS

Source: https://www.cdc.gov/group-a-strep/php/ltcf-toolkit/

Identify potential asymptomatic carriers

Screen

Screen (by culture) close contacts of ill resident, including roommates and close social contacts.

Sites to culture include

- Throat
- Skin lesions
- Ostomy sites [C]

Treat

Treat anyone with a positive culture. Review the page on **antibiotic regimens** for detailed guidance.

Re-screen

Re-screen, by culturing the same sites listed above, anyone with a positive culture 7 to 10 days after they complete treatment. Treat anyone with a positive culture.

 Source: https://www.cdc.gov/group-a-strep/php/ltcf-toolkit/

Assess infection control measures

Review and audit infection control practices for **wound and respiratory care** in addition to the following standard infection control practices:

- Hand hygiene, preferably using alcohol-based hand rub/sanitizer
- Appropriate selection and proper use of personal protective equipment (PPE) [E]
- Cleaning and disinfection of environmental surfaces and reusable wound care equipment [F]
- Maintaining separation between clean and soiled equipment to prevent cross contamination
- Dedicating multidose medication containers to a single patient or resident whenever possible [G]

Considerations for multidose medication containers

If multidose medication containers are used for more than one resident, restrict the medication containers to a centralized medication area. Don't bring them into the immediate resident treatment area (e.g., resident room/cubicle).

 Source: https://www.cdc.gov/group-a-strep/php/ltcf-toolkit/

Provide staff education

Educate HCP on signs and symptoms of GAS infection and the importance of not working while ill.

Conduct policy review

Review sick leave policies.

Additional considerations

- Consider restricting visitors for a limited time period.
- Consider placing residents with GAS infection and HCP caring for these residents in cohorts.
- Consider halting new admissions in affected units or floors.

 Source: https://www.cdc.gov/group-a-strep/php/ltcf-toolkit/

Identifying Potential Asymptomatic Carriers

1 Case

Screen

Screen (by culture) close contacts of ill resident, including roommates and close social contacts.

Sites to culture include

- Throat
- Skin lesions
- Ostomy sites [C]

Treat

Treat anyone with a positive culture. Review the page on **antibiotic regimens** for detailed guidance.

Re-screen

Re-screen, by culturing the same sites listed above, anyone with a positive culture 7 to 10 days after they complete treatment. Treat anyone with a positive culture.

2 Cases

Screen

Screen **all residents** [C] by culture, except those on GAS treatment within the last 14 days.

Sites to culture for residents:

- Throat
- Skin lesions
- Ostomy sites [D]

Consider screening **epidemiologically-linked HCP** by culture, except those on GAS treatment within the last 14 days.

Sites to culture for HCP:

- Throat
- Skin lesions

Treat

Treat anyone with a positive culture. Review the page on **antibiotic regimens** for detailed guidance.

Re-screen

Re-screen, by culturing the same sites listed above, anyone with a positive culture 7 to 10 days after they complete treatment. Treat anyone with a positive culture.

3+ Cases

Screen

Screen **all residents** [C] by culture, except those on GAS treatment within the last 14 days.

Sites to culture for residents:

- Throat
- Skin lesions
- Ostomy sites [D]

Screen **epidemiologically-linked HCP** by culture and consider screening all HCP [E] except those on GAS treatment within the last 14 days.

Sites to culture for HCP [F]:

- Throat
- Skin lesions

Treat

Treat anyone with a positive culture. Review the page on **antibiotic regimens** for detailed guidance.

Re-screen

Re-screen, by culturing the same sites listed above, anyone with a positive culture 7 to 10 days after they complete treatment. Treat anyone with a positive culture.

Source: https://www.cdc.gov/group-a-strep/php/ltcf-toolkit/

Active Surveillance

Keep looking for other cases

Maintain active surveillance for invasive or noninvasive cases among LTCF residents for **4 months** from onset of most recent GAS case.

 Source: https://www.cdc.gov/group-a-strep/php/ltcf-toolkit/

Group A Strep Outbreaks in Nebraska

Since January 2025:

- Investigated 37 HAI cases of invasive GAS
- Cases were linked to postpartum care, surgical procedures, assisted living facilities, and LTCFs.
- Outbreak transmission has been linked to colonized staff, colonized residents, and wound care

Source: Numbers provided by Nebraska Electronic Disease Surveillance System (NEDSS)

Lessons Learned

Wear a mask when recovering from respiratory illness

Proper wound care practices

Hand hygiene, dedicated patient care supplies, PPE, etc.

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Home | Programs | Center for Health Care Quality | Healthcare Associated Infections | Monitoring Adherence to Healthcare Practices that Prevent Infection

HEALTHCARE-ASSOCIATED INFECTIONS (HAI) PROGRAM

Monitoring Adherence to Health Care Practices that Prevent Infection

Healthcare facilities should implement processes to regularly monitor healthcare personnel (HCP) adherence to evidence-based infection prevention and control (IPC) practices and provide performance feedback to HCP and leadership. The following tools may be used to observe and measure HCP adherence to IPC practices while performing specific types of care. Local public health may also use these tools as part of healthcare facility IPC consultations. **Select topics below to find associated adherence monitoring tool(s) and resources.**

Blood Glucose Monitoring

Central Line

Device Reprocessing

Enhanced Barrier Precautions

Wound Care

IPC practices while performing wound care can reduce the spread of infections including Group A Streptococcus (GAS).

Adherence Monitoring Tool

- Wound Care (PDF)
  Use this tool anywhere patients or residents are receiving wound care.

Additional Resources

- Infection Prevention During Wound Care (PDF)
- Invasive Group A Streptococcus: An Overview for Long-Term Care Facilities (PDF)
- EMBRACE Modules

Source: https://www.cdph.ca.gov/programs/chcq/hai/pages/monitoringadherencetohcpracticesthatpreventinfection.aspx

State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities

Examples of Level 2, no actual harm with potential for more than minimal harm that is not immediate jeopardy include, but are not limited to:

- The facility failed to ensure that its staff demonstrates proper use of gloves with hand hygiene between residents to prevent the spread of infections. The nurse administered medications to a resident via a gastric tube and while wearing the same gloves proceeded to administer oral medications to another resident. The nurse did not remove the used gloves nor perform hand hygiene between the two residents.
- The facility failed to implement appropriate measures for the transport of contaminated linens. As a result, the potential exists for transmission of organisms from contaminated uniforms to residents during the delivery of care. A nursing assistant was observed removing bed linens contaminated with urine and fecal material without the use of gloves and gown, and carrying the contaminated linens against his/her uniform to the laundry bin. The nursing assistant proceeded to assist the resident's roommate with transferring to his/her chair, and his/her uniform made contact with the resident's skin and clothing.

- The facility failed to ensure that a staff member implemented appropriate processes related to handling and storing wound care supplies. As a result, the potential existed for transmission of organisms between residents who received dressing changes. A staff member who was providing wound care, was observed to place dressing supplies on one resident's bedding and after completing the dressing change, placed the supplies, which are used for other residents, in the unit's dressing cart.

Source: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Cleaning + Disinfection of wound care devices

Routine Audit of Infection Prevention & Control Practices

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State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities

Process Surveillance

Process surveillance is the review of practices by staff directly related to resident care.[27] The purpose is to identify whether staff implement and comply with the facility's IPCP policies and procedures. Some areas that facilities may want to consider for process surveillance are the following:

- Hand hygiene;
- Appropriate use of personal protective equipment (e.g., gowns, gloves, facemask);
- Injection safety;
- Point-of-care testing (e.g., during assisted blood glucose monitoring);
- Implementation of infection control practices for resident care such as but not limited to urinary catheter care, wound care, injection/IV care, fecal/urinary

Source: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Infection Control Assessment and Response (ICAR) Tool for General Infection Prevention and Control (IPC) Across Settings

Module 8. Wound Care Facilitator Guide

Wound Care: This form is intended to aid an ICAR facilitator in the review of wound care practices at the healthcare facility (Part A) and guide observations (Part B). For the purposes of this tool, wound care refers to local care (e.g., debridement, dressing changes) to facilitate healing of breaks in the skin (e.g., ulcers, surgical wounds). While the practices being assessed (e.g., prevention of cross-transmission) apply wherever wound care is performed, the level of detail included in the tool is likely not sufficient to fully assess practices in specialty areas like burn units.

Part A. Wound Care Interview Questions

1. What type(s) of wound care activities are performed at the facility? (select all that apply)
   - ☐ Dressing changes
   - ☐ Irrigation
   - ☐ Sharp debridement
   - ☐ Wound vac management
   - ☐ Unknown
   - ☐ Not Assessed
   - ☐ Other (specify):

2. Which of the following categories of HCP provide wound care and what activities do they perform? (select all that apply)
   - ☐ Dedicated (in-house) wound care team
     If ***YES***, describe services provided:
   - ☐ Dedicated (external/consultant) wound care team
     If ***YES***, describe services provided:

Source: https://www.cdc.gov/infection-control/media/pdfs/IPC-mod8-wound-care-508.pdf

CDPH California Department of Public Health

Healthcare-Associated Infections Program
Adherence Monitoring
Wound Care

Facility Name:	
Unit:	
Date:	
Completed By:	
Start Time:	
End Time:	

Regular adherence monitoring with feedback of results to staff can maintain or improve adherence to wound care practices. Use this tool to identify gaps and opportunities for improvement. Monitoring may be performed in any location where patients receive wound care. Wound care includes, but is not limited to, dressing management, wound irrigation, wound vac use, colostomy care, and surgical incision care.

Instructions: **(1)** Observe wound care from start to finish. Record if steps were performed as *Yes* or *No*. **(2)** After observations, record the total number of *Yes* responses and the total number observed (*Yes* + *No*) in the columns to the far right. **(3)** Calculate and record an adherence percentage at the end of this tool. Use the *Notes* section to record additional relevant information.

Role/Discipline Key:
C = Wound Care Consultant/Contractor **N** = Facility Nurse **P**= Facility Physician/Independent Practitioner

Wound Care Practices		Observation 1	Observation 2	Observation 3	Observation 4	Adherence by Task	
						# Yes	# Observed
	Role/Discipline	☐C ☐N ☐P	☐C ☐N ☐P	☐C ☐N ☐P	☐C ☐N ☐P		
WC1	Hand hygiene is performed before gathering supplies.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
WC2	A clean work space is selected; all supplies are gathered and positioned in a way to prevent contamination.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
WC3	Multiuse medications are dedicated for a single patient or dispensed prior to going into the patient care area.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
WC4	Hand hygiene is performed prior to wound care.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
WC5	Appropriate PPE is donned, including eye protection for actions that may produce splashing.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		

Source:https://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/AdherenceMonitoring_WoundCare.pdf

Healthcare-Associated Infections Program
Adherence Monitoring

Environmental Cleaning and Disinfection

Facility Name:
Unit:
Date:
Completed By:

Regular monitoring with feedback of results to staff can maintain or improve adherence to proper environmental cleaning and disinfection practices. Use this tool to identify gaps and opportunities for improvement. Monitoring may be performed in any type of patient care location.

Instructions: **(1)** Observe 2 or more environmental services (EVS) staff. Check *Yes* or *No* for each observed practice; leave blank if not applicable or there was no opportunity to observe the practice. **(2)** After completing all observations, record the total number of *Yes* responses and the total number observed (*Yes* + *No*) in the columns to the far right. **(3)** Calculate and record an adherence percentage at the end of this tool.

	Environmental Cleaning Practices	EVS 1	EVS 2	EVS 3	Adherence by Task	
					# Yes	# Observed
EVS1	Cleaner/disinfectant is an EPA-registered solution approved for use at healthcare facility.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
EVS2	EPA-registered cleaner/disinfectant agent is appropriate for the pathogen(s) of concern, e.g., a List K agent is used for the room of a patient with C. difficile infection, or a List P agent is used on the unit where a Candida auris outbreak is occurring).	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
EVS3	Cleaner/disinfectant is premixed, or EVS staff can verbalize the correct mixing procedure and storage requirements according to manufacturer's instructions.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
EVS4	Solution remains in wet contact with surfaces for sufficient time according to manufacturer's instructions.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
EVS5	Cleaning process avoids contamination of solutions and cleaning tools; a clean cloth is used in each patient area, and the cloth is changed when visibly soiled.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
EVS6	Proper sequence of cleaning and disinfection (e.g., from top to bottom, clean to dirty, and a standardized pattern) are followed to avoid cross-contamination.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		

Source: https://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/AdherenceMonitoring_EVS.pdf

Healthcare-Associated Infections Program
Adherence Monitoring

Enhanced Barrier Precautions (EBP)

Facility Name:
Unit:
Date:
Completed By:

Regular monitoring with feedback of results to staff can maintain or improve adherence to EBP practices. Use this tool to identify gaps and opportunities for improvement. Monitoring may be performed in any type of resident care location where residents are on EBP. Refer to the infographics at the end of this tool to determine if EBP is indicated for the resident.

Instructions: **(1)** Observe 3 or more residents on EBP. Check *Yes* or *No* for each observed practice; leave blank if not applicable or there was no opportunity to observe the practice. **(2)** After completing all observations, record the total number of *Yes* responses and the total number observed (*Yes* + *No*) in the columns to the far right. **(3)** Calculate and record an adherence percentage at the end of this tool.

	Enhanced Barrier Precautions	Resident 1	Resident 2	Resident 3	Resident 4	Adherence by Task	
						# Yes	# Observed
EBP1	Personal protective equipment (PPE), including gloves and gowns, are available and located near point of use.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
EBP2	An EBP sign is posted and is easily visible (see page 3 for examples).	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
EBP3	In multi-bed room, each resident's bed space is treated as a separate room (care provider performs hand hygiene and changes PPE between each resident in same room).	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
EBP4	Hand hygiene is performed before entering the resident care environment, if hands or gloves become visibly soiled, and between glove changes.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
EBP5	Gloves, gown, and other PPE as necessary (e.g., face shield if splash or spray anticipated) are donned before performing high-contact tasks (e.g., bathing, toileting).	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		

Source: https://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/AdherenceMonitoring_EBP.pdf

QUESTIONS?

Claire Ortlieb, MPH |HAI Epidemiologist

Claire.Ortlieb@Nebraska.gov | (402) 560-0154