Designing a Conference Poster

Dr. Kerry Flint

Primary Objective

Encourage the sharing of great ideas, successful projects.

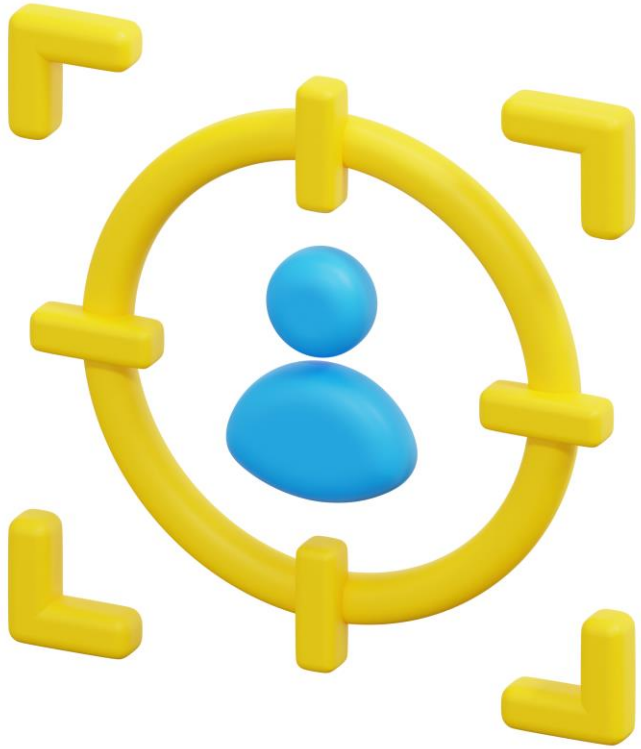
Encourage conference posters for the APIC NM Conference in April 2023.

Posters: the what & the why

- Large format 1-page summary of a project
- Provides a way to communicate the problem, the methods, and outcomes of project

Who is your audience?

- Topic should be relevant to the intended audience
- Audience often determined by the type of conference



Call for Posters

Each conference will have its own process.

Often you will see a call for posters with a submission date

- Review different categories
- Submit an abstract

Once accepted/ start building your poster

Submitting an Abstract

Stand alone summary of the project/research

Often published in journal supplement or on conference websites

Often has a specific template and word limit (e.g. 350 words)

Do not include images or graphics – save those for your poster

Key components:

- Background
- Methods
- Results
- Conclusion

Example

Poster Abstracts

Call for Poster Abstracts 2023

Poster presentations convey innovative, clinically relevant information that enhances the professional skills of mental healthcare professionals. The Poster Sessions provide presenting authors a forum in which they can showcase their work and interact with conference attendees. We are seeking poster submissions from these areas:

- Research Reports
- Research in Progress
- Case Reports
- Repeat Presentations

Submit Your Poster

Additional Information

Important Dates

- Abstract Submission Site Closes: Monday, July 31, 2023 at 11:59 pm
- Notification of acceptance or rejection: First week of each month, beginning in March 2023 (rolling acceptance)
- Withdrawal date: July 31, 2023
- PDF Posters Due: August 30, 2023

Questions?

For questions regarding the abstract process, please contact callforabstracts@psychcongress.com.

APIC Tools

https://apic.org/Resource_/TinyMceFileManager/Periodical_images/PS_Summer_2017_Abstract_submission.pdf

PREVENTION IN ACTION

Moving from wishing to success:

Pointers for a successful abstract submission

BY JAN RATTERREE, BSN, RN, CIC, AND JULIE BLECHMAN, MPH, CHES

Have you ever attended a scientific conference and seen the rows and rows of abstract posters, wishing yours was among them? Abstracts are concise research papers that help advance the field of science and add to the body of evidence-based literature.

Each year, APIC posts a Call for Abstracts. At this time, members of the infection prevention community may submit their research for consideration as a poster or oral session for Annual Conference. Abstracts are then peer-reviewed for quality of research, educational or scientific content, presentation logic, and impact on the infection prevention and control field.

APIC invites the authors of accepted abstracts to present their posters to Annual Conference attendees. This year, the APIC 2017 Annual Conference Committee accepted more than 200 abstracts in the form of oral and poster presentations.

Being selected as an abstract presenter not only advances the infection prevention field, it advances your career as well. Oral presentation at the state, regional, or national level, or poster presentation at the national level, are criteria for the Fellow of the Association for Professionals in Infection Control and Epidemiology (FAPIC) credential.

So…how can you change from wishing for an accepted poster to celebrating your success? The solution is simple: **Plan your work and work your plan**.

Plan to submit an abstract on your research project before you start the work, and then work your project according to the plan. This might seem like a circular way to conduct your research, but it does work. The following three steps can help you successfully submit abstract.

1 Utilize the APIC resources in planning your abstract and begin planning with the rules. Review carefully the Call for Abstracts on the APIC Annual Conference website. The most common mistakes are made by not following the rules.

2 Another excellent tool for planning your work is the APIC Video "Writing Scientific Abstracts" by Kate Gase, MPH, CIC, FAPIC. Kate describes the basic sections of the abstract. Review the video throughout the entire research and writing process. (https://tinyurl.com/APICabstractvideo)

3 While planning, seek a mentor who has previously presented at conference to review your work. Mentors can help guide you from the beginning planning stages, through study implementation, and writing stages. Visit MyAPIC (http://community.apic.org/myapic/home) to get connected with a mentor, or reach out to members of your local APIC chapter.

The most common reasons APIC Annual Conference abstracts are rejected:

- It has been previously published.
- The entry was faxed or mailed, and not electronically submitted.
- The abstract was submitted after the deadline.
- Brand or trade names are used in the abstract.
- It is longer than 300 words.
- It is poorly written.

Make sure you also familiarize yourself with abstract awards (see Abstract Award and Criteria on page 51). Quality work, combined with meeting the criteria for an award, can elevate your work from successful acceptance to award winning recognition. Use the same basic work management tool and reach for the stars!

We look forward to seeing your quality abstract submissions for the APIC 2018 Annual Conference, which will take place June 13-15, 2018, in Minneapolis, Minnesota! Visit the conference website for more information.

Jan Ratterree, BSN, RN, CIC, is the chair of the Abstracts Subcommittee of the 2017 Annual Conference Committee. She has 28 years of experience in nursing, management, and staff education, followed by over 10 years as an infection preventionist. Julie Blechman, MPH, CHES, is the APIC communications manager and a handwashing enthusiast.

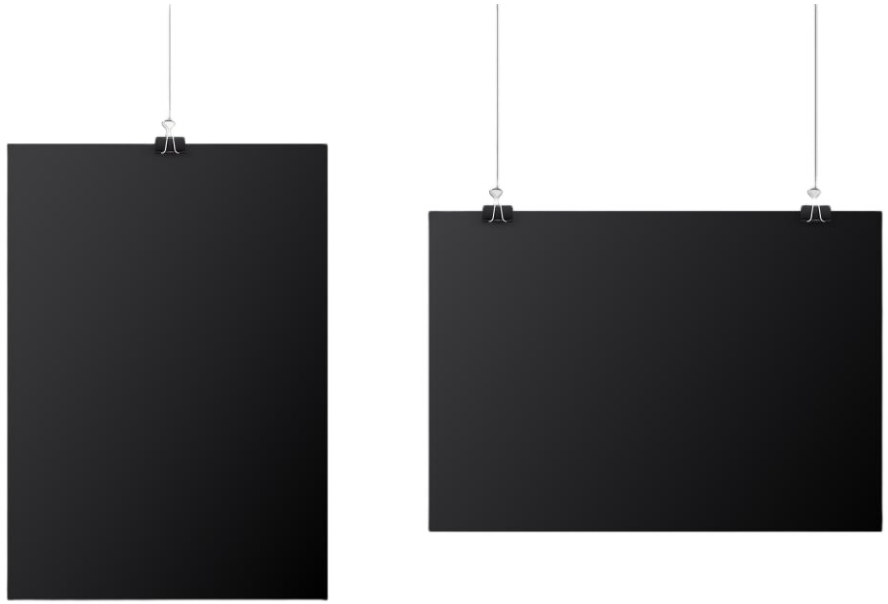
Building the Poster

Format

Check the conference requirements

May include specific

- Templates
- Sections
- Size
- Orientation



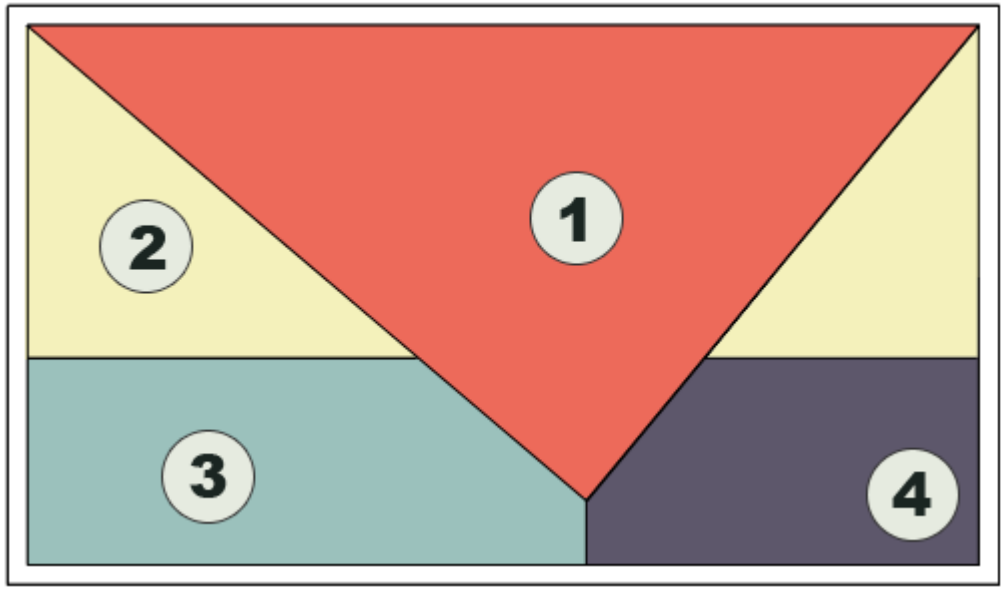
Format Tips

Be concise

- Limit text 800-1000 words

Presentation

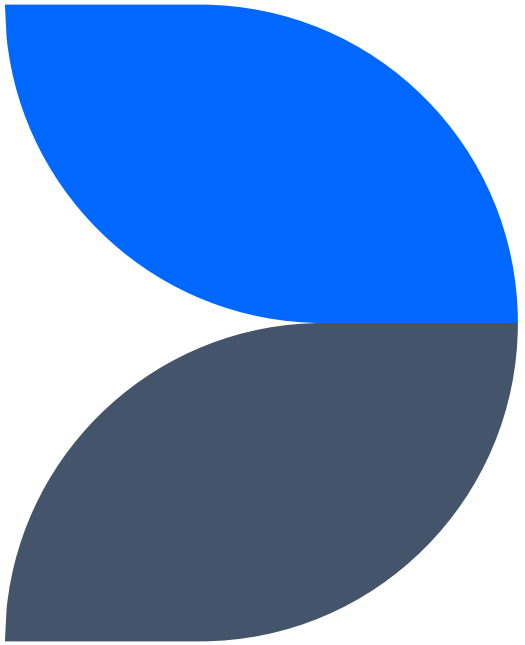
- Font size & spacing
- Reader flow
- White space
- Graphics – graphs charts, images



https://writing.wisc.edu/handbook/assignments/posterpresentations/

Key Sections

Title
Introduction
Method
Results
Discussion



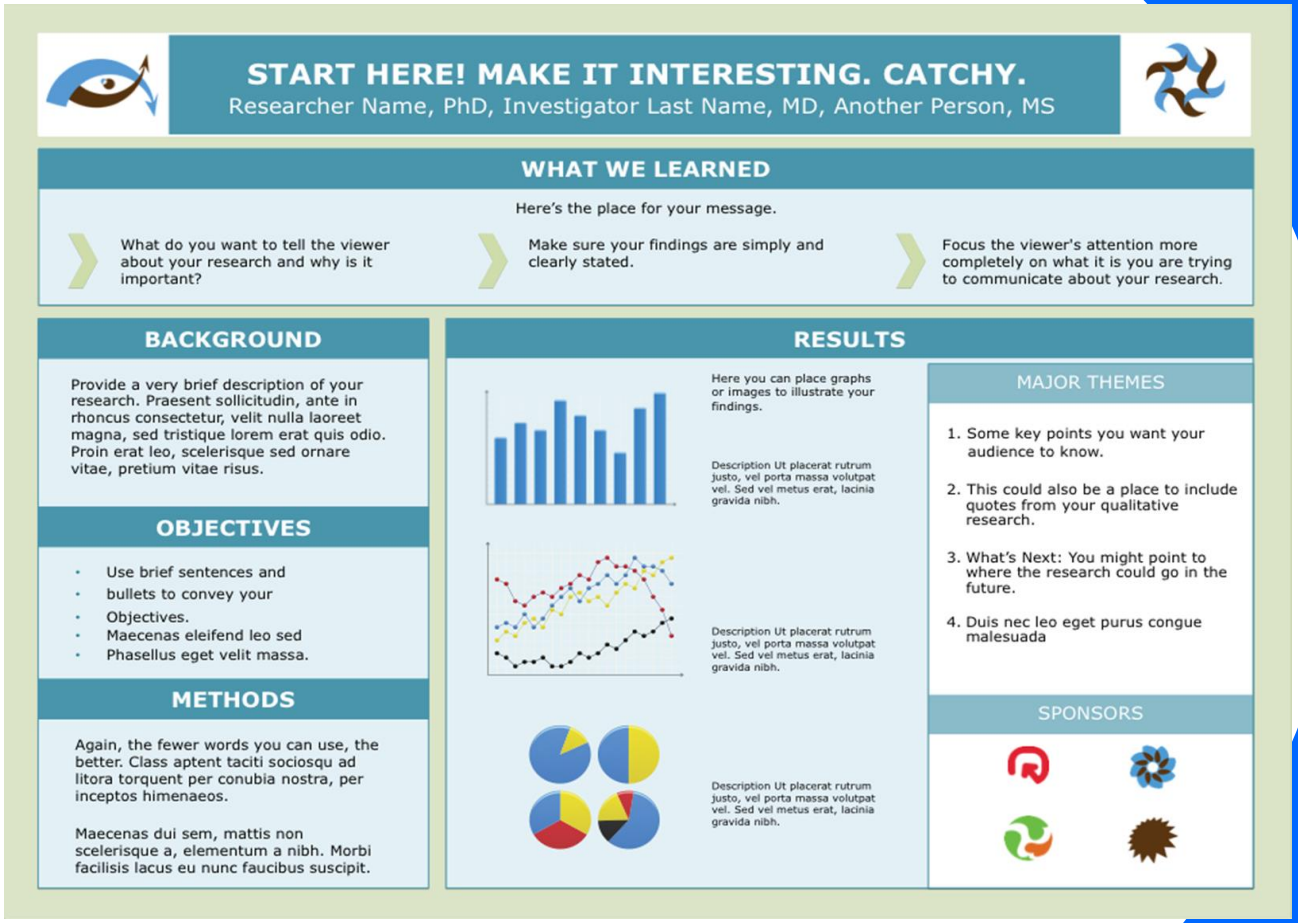
The Title

Get Creative

Select an interesting title

Make it Catchy

Include the names of key people involved in the project

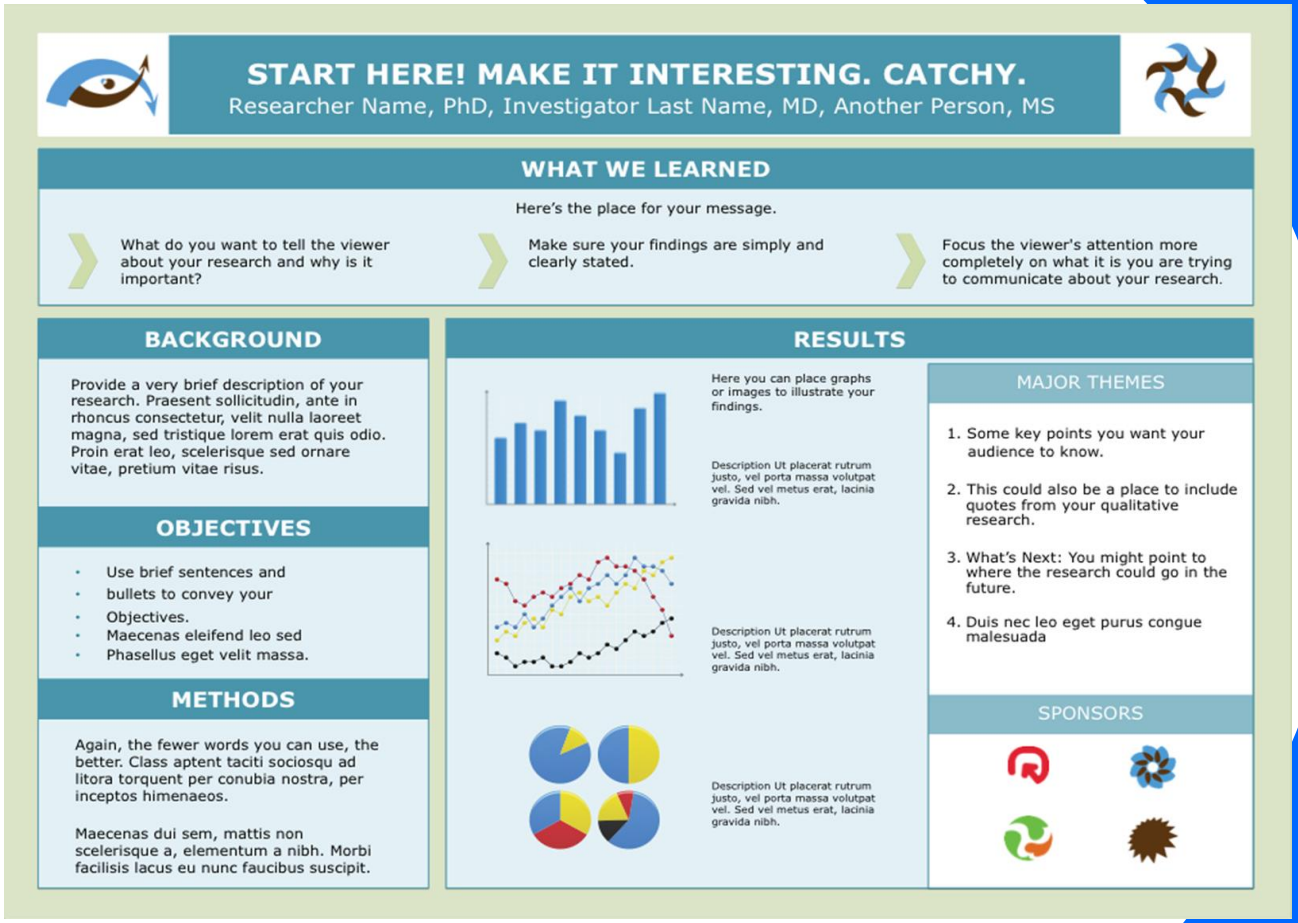


The Introduction

Also called the background section

Describes the problem or the gap that formed the basis for your project.

This might also be the research question

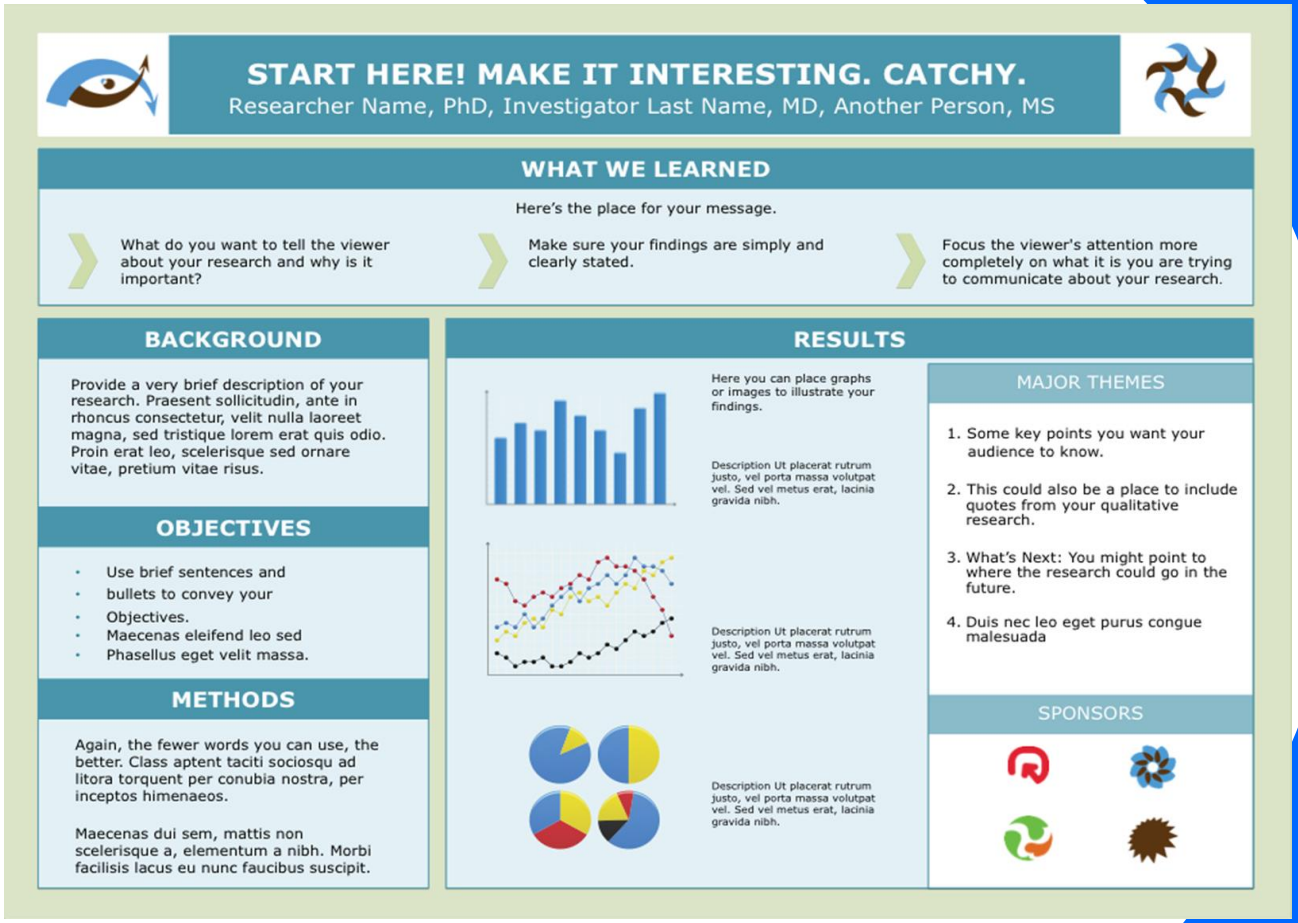


The Method

The method is the how-to section.

Describes the project/research

- the study design (PI Project-PDSA, Retrospective)
- Participants/population (ICU, out-patients, clinical staff)
- How data was collected (audits, surveys)
- Statistical methods

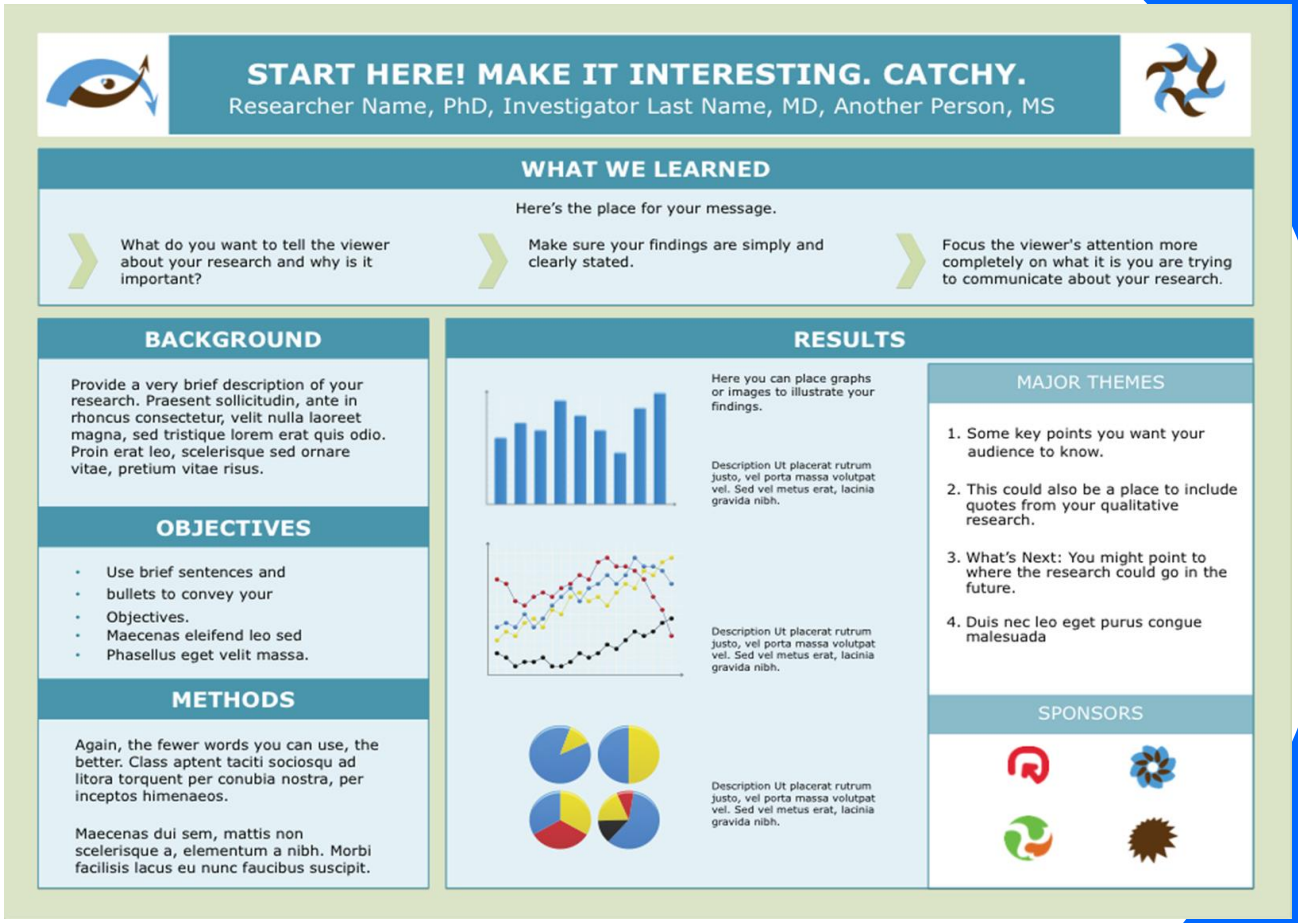


The Results

Brief description of findings

Use graphs and charts to describe results

Be sure the results reflect the problem or research question identified in the introduction section.

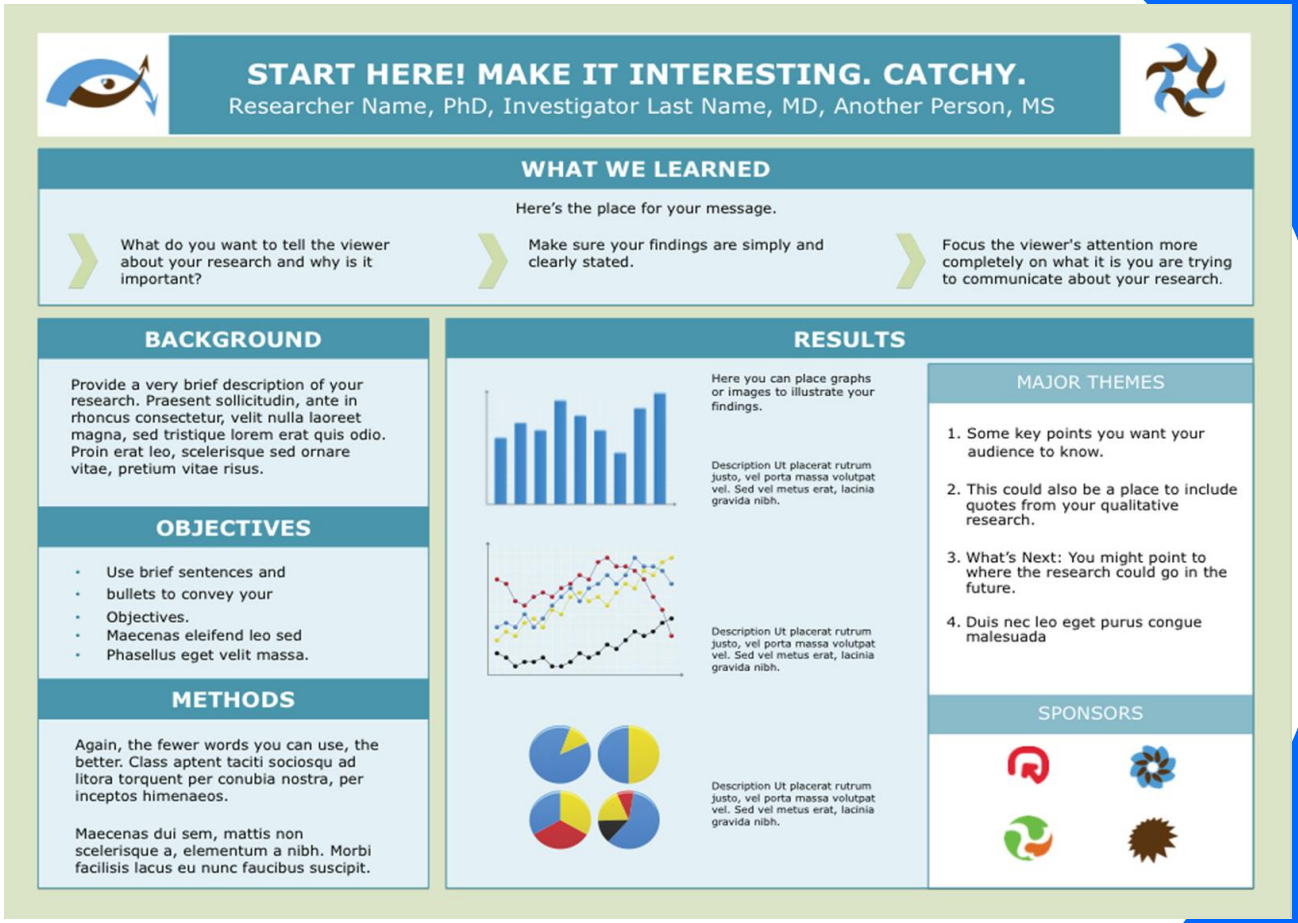


The Discussion

May be the conclusion- a summary of the key take aways

Might include

- Successes/ lessons learned
- Expected or unexpected results
- Future research opportunities or next steps



Poster FAQ

Printing

- Triple check for formatting and typos
- Check again – new eyes
- Allow plenty of time for delivery
- Some conferences may print your presentation for you – Check submission dates!

Transport

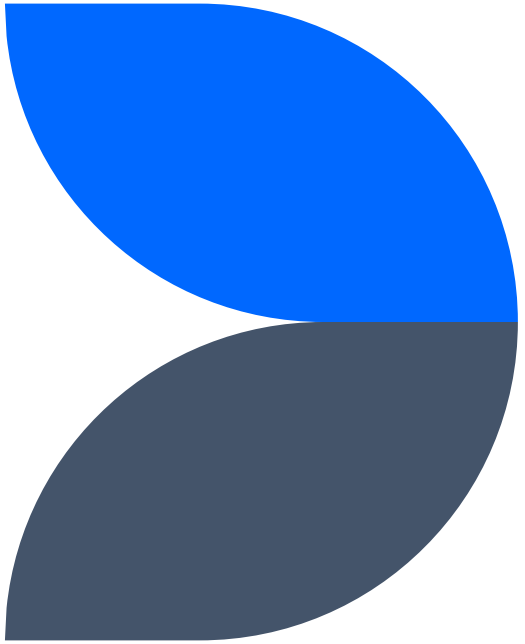
- Cardboard or Plastic carriers
- If being printed- consider how to take home

Supplies

- Where and how are the posters being displayed.
- Thumb tacks
- Hand Outs
- Business cards

The Presentation

- Engage with the audience
- Be prepared for questions
- Provide contact information
  - QR Code
- Virtual Presentations
  - Web-based conferences
  - Recorded Abstract



Poster Ideas

Projects- Big or Small

Process Changes

Lessons Learned

Capstone Projects

Implementation of New Process or Pro

APIC NM Annual Conference

- April 14, 2023
- Call for posters- Abstract Submission due March 14, 2023
- Send submissions to

  president.apic32@gmail.com

The Effects of Mindfulness Therapy on PICU Nurses' Self-Reported Levels of Job Satisfaction, Retention, Burnout and Compassion Fatigue

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COLLEGE of CENTRAL FLORIDA

RN-BSN Program
Health Sciences Division

ABSTRACT

The demands of being a pediatric intensive care unit nurse have been associated with high stress levels and increased incidences of burnout, compassion fatigue, secondary traumatic stress, job dissatisfaction, and high attrition rates. Many healthcare organizations lack programs directed at promoting self-care behaviors for PICU nurses. Mindfulness therapy is a complementary alternative therapy that uses mediation and awareness of one's self and situation to positively cope with life's stressors. The purpose of this study will evaluate the effectiveness of an eight week long mindfulness therapy training program. Following a quasi-experiment nonequivalent control group pretest-posttest design, approximately 40 nurses will be purposively selected from two pediatric intensive care unit (PICU) settings in two different metropolitan hospitals to serve in either the intervention group or comparison group. After obtaining IRB approval, facility ethics committee approval, and signed informed consent forms from participants, five pre-test questionnaires to assess levels of burnout, compassion fatigue, emotional labor, job satisfaction, retention, and mindfulness will be completed. Multiple linear regression analysis will be used to determine significant relationships between variables. Reliability-Corrected Analysis of covariance (ANCOVA) will be utilized to reduce the effects of the initial differences between the comparison and intervention group.

PROBLEM

Nursing is founded on the beneficence of caring for others, but who cares for the nurses? Daily, PICU nurses provide specialized care to high acuity patients. These nurses experience the tragedies of children suffering and dying as well as the miracles of saving a precious life. Being exposed to every conceivable emotional response from grief-stricken parents and the stressors associated with this type of intensive work is emotionally laborious and can lead to symptoms of BO, CF or ultimately a nurse leaving his or her position. Hostile work environments, lack of staffing, and perceived lack of support further compound stressors contributing to nurse attrition rates (Hinderer,et al., 2014; Shoni, Bonnie, & Celeste, 2013).

PURPOSE

The purpose of this study is to evaluate the effectiveness of an 8 week long mindfulness therapy program on PICU nurses' self-reported levels of burnout, compassion fatigue, job satisfaction, retention, and mindfulness.

SIGNIFICANCE TO NURSING

In the current era of widespread nursing shortages and higher productivity demands with fewer resources, developing positive coping mechanisms and strategies for managing stressful work environments is invaluable in facilitating nurses in retaining their positions, increasing their job satisfaction, and decreasing the occurrence of burnout and compassion fatigue. This study will contribute to the understanding of how mindfulness therapy can contribute to promoting positive coping mechanisms in PICU nurses and serve as an example of possible institutional instruction on addressing this phenomenon.

RESEARCH DESIGN

This study will be a quasi-experiment nonequivalent control group pretest-posttest design that will evaluate the effectiveness of an eight week long mindfulness therapy training program on self reported levels of burnout, compassion fatigue, secondary post traumatic stress, and attrition rates. Comparing changes of the intervention group on self reported data collected pre and post intervention versus a comparison group not receiving the intervention.

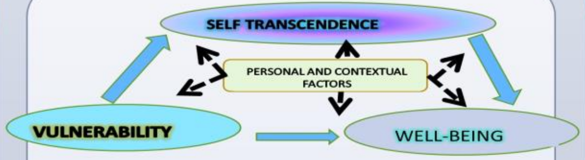
THEORETICAL/CONCEPTUAL FRAMEWORK

Pamela Reed's Self-Transcendence Theory (1991) was developed through deductive reformulation of non nursing lifespan theories drawing heavily from Roger's conceptual system of unitary beings. The theory was originally intended for mental illness but was quickly adapted to end of life events and traumatic life events. The three main concepts of this theory are vulnerability, self-transcendence, and well-being. Vulnerability is being aware of one's own mortality, often accompanying aging, life phases, and life crises. Self-transcendence describes the fluctuation of perceived boundaries that can extend a person beyond the immediate and contracted self view. Well-being is feeling healthy within the context of one's own standards of healthy. Persons experiencing end of life events or traumatic events are in a state of increased vulnerability which can increases self transcendence; self transcendence is positively related with well being and mediates between vulnerability and well being; personal and contextual factors may influence relationships between the concept (Alligood, 2014). Activities that have been suggested to facilitate growth of self-concept boundaries include journaling, music, art, meditation, life review, and religious expression. Nursing activities that engage self reflection, altruism, hope, faith, in vulnerable populations are associated with increased well being, as well as using group therapy to help clients examine their values and share their experiences with others with similar stories. Alligood (2014) refers to self transcendence perspectives correlating with lower levels of burnout in hospice and oncology nurses and with higher levels or work engagement in acute care nurses. Mindfulness therapy enhances one's self-transcendence by encouraging awareness, introspection and reflection; which increase wellbeing. Self-transcendence theory serves as framework to conceptualize Mindfulness Therapy.

According to the literature, sociological researchers Maslach and Jackson (1981, 1996) have been integral in developing the most widely used instrument for assessing BO, the Maslach Burnout Inventory. Even in the 1970s, researchers had already made the connection that burnout affects the quality of care provided, was predictor for of turnover rates, absenteeism, and low morale. Additionally, burnout was correlated with self-reported incidents of physical exhaustion, insomnia, and increased use of alcohol, drugs, and martial problems.

Researchers Cheng, Bartram, and Karimi (2013) examined the relationship between emotional labor, team climate, burnout, perceived quality of care and turnover intention among nurses in Australia. The researchers define emotional labor as the "regulation of emotion during interpersonal transactions." Major concepts including faking unfelt emotions, hiding genuine emotions, and deep acting where one attempts to influence their inner feelings to induce the appropriate outward countenance. The findings from the study suggest that relative to deep acting, surface acting can have negative effects on nurses' wellbeing and self rated performance, and is more predictive of burnout. The researchers define emotional labor as the "regulation of emotion during interpersonal transactions." Major concepts explored in the study included faking unfelt emotions, hiding genuine emotions, and deep acting which pertains to one's attempt to influence their inner feelings to induce the appropriate outward expression. The findings from the study suggest that relative to deep acting, surface acting can have negative effects on nurses' wellbeing and self rated performance, and is more predictive of burnout.

Cricco-Lizza (2014) uses an ethnography framework to guide her qualitative approach to examine the emotional labor and coping strategies of NICU nurses by firsthand observation of the nursing culture in a children's hospital in the northeastern United States. This study examined 114, level-4, NICU nurses over 14 months in their everyday lives in order to better understand their emotional labor and coping strategies for dealing with the stressors of the field. Glimpses into these first hand experiences and self reported accounts of NICU nurses illuminates the true toll high



METHODS: SAMPLING, SUBJECTS, & SITES

Approximately 40 participants will be purposively selected from two pediatric ICU settings in two different metropolitan hospitals. Group A of twenty PICU nurses will participate in one hour long weekly mindfulness therapy training sessions during their day off for eight weeks. Group B will be serving as a comparison group and will only receive pre and post testing inventories to complete. Inclusion criterion will be a minimum of one year current experience in the PICU as a floor nurse. Nurse mangers and educators will be excluded from the sample size as well as advanced nursing degrees.

INSTRUMENTS

A Demographic/Behavioral instrument will assess demographics, personal/environmental characteristics (age, years nursing, sex, ethnicity, education and marital status), coping strategies, stress relief strategies, support systems, job satisfaction, relationship with coworkers, percentage of time in direct patient care, hours per shift, hours worked per week and unit. Multiple choice and Likert-style questions will be included in this instrument. (Hinderer, et al., 2014).

The Professional Quality of Life Scale (ProQOL) is a 30 item tool that uses Likert-type responses that range from 0(never) to five (very often) on BO, CF, CS. The reliability in Cronbach alpha for each subscale is CS = 0.87, CF = 0.80, BO = 0.72. (Hinderer, et al., 2014).

he Maslach Burnout Inventory (MBI) is a 22 item scale measuring burnout. The MBI subscales focus on three aspects of BO: personal accomplishment, depersonalization, and emotional exhaustion. Reliability coefficients for each subscale are 0.9 for emotional exhaustion, 0.79 for depersonalization, and 0.71 for personal accomplishment (Gallagher & Growley, 2009). Test-Restest reliability has revealed adequate correlations ranging from 0.5-0.82 over a period of three months to one year (Davis, Lind & Celeste, 2013).

Retention or turnover probability was assessed with the turnover intention subscale of the Michigan Organizational Assessment Questionnaire. It is a three-item scale, which is measured on a 7-point Likert scale with 1 = 'Strongly disagree'–7 = 'Strongly agree'. Cronbach's alpha for this scale was 0.90 (Hinderer, 2014).

The Five-Facet Mindfulness Questionnaire (FFMQ) is 39-item measure that assess mindfulness and its five facets: observing, describing, acting with awareness, non-judging of inner experience, and non-reactivity to inner experience. The FFMQ was derived from a factor analysis of five independently developed mindfulness inventories. Authors Park, Reilly-Spong, and Gross (2013) note in their study that internal consistency of the FFMQ is adequate with Cronbach's alphas for the five subscales ranging from 0.67 to 0.93. Construct validity for the FFMQ may be evidenced by the strong correlations with openness, emotional intelligence, self compassion,and well-being, and negative correlations with neuroticism, depression, anxiety, and dissociation (p.2652).

DATA ANALYSIS

Data will be analyzed using SPSS software. Multiple linear regression analysis will be used to determine significant relationships between variables. Factor analysis will be used to detect relationships between the variables being studied. Reliability-Corrected Analysis of covariance (ANCOVA) will be utilized to reduce the effects of the initial differences between the comparison and intervention.

ETHICAL IMPLICATIONS

Prior to collecting any data, approval from each metropolitan hospital's ethics committee and the Institutional Review Board (IRB) will be obtained. Study introductory letters and informed consents will be attached by unit managers to paystubs of potential participants. The letter will indicate the purpose of the study, that participation will be voluntary, minimal risk will be involved, that all information will be strictly confidential through removal of visible personal information and a unique coding system of a letter and number will be assigned to each participant. Signed informed consents from eligible voluntary participants will be collected prior to administering any questionnaires. Questionnaires will be available to participants via hardcopy, email, or automated telephone prompt.

CONCLUSIONS

Understanding how to enhance job satisfaction and retention while reducing the emotional labor, burnout and compassion fatigue associated with high stress nursing jobs is integral in the development of organizational guided social interventions to address this problem. Researching interventions that organizations can implement to enhance the coping mechanisms and wellbeing of their medical staff members is vital to sustaining a system of quality care simply because if a nurse cannot care for him or herself, then how can he or she be expected to care for a patient's wellbeing?

Without healthcare organizations promoting positive coping mechanisms and self care behaviors workshops for the nurses that bare the burden of the most emotionally and physically laborious clients, then the attrition rates for PICUs and other intensive care units alike will likely increase. Despite self reported levels of burnout, many nurses still reported high compassion or job satisfaction and fulfillment with their jobs (Ebb, 2009; Davis, et al, 2013; Cricco-Lizza, 2014; Gallagher & Gromley, 2014). This speaks to the nature of nursing being that of true nurturance and sacrifice; but the sacrifice of nurses' personal wellbeing can come at the cost of patient care. PICU nurses need to take care of themselves first and foremost so that they can be in the best state physically, mentally, and spiritually for patients in order to provide quality client-centered care. Healthcare organizations need to focus on providing healthcare workers with support systems that promote self care behaviors, positive coping mechanisms and resilience in the face of the most dire and heart breaking situations imaginable. Mindfulness Therapy shows promise in providing a cost effective means at improving retention through awareness, insight, and self-transcendence.

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START HERE! MAKE IT INTERESTING. CATCHY.

Researcher Name, PhD, Investigator Last Name, MD, Another Person, MS

WHAT WE LEARNED

Here's the place for your message.

- What do you want to tell the viewer about your research and why is it important?
- Make sure your findings are simply and clearly stated.
- Focus the viewer's attention more completely on what it is you are trying to communicate about your research.

BACKGROUND

Provide a very brief description of your research. Praesent sollicitudin, ante in rhoncus consectetur, velit nulla laoreet magna, sed tristique lorem erat quis odio. Proin erat leo, scelerisque sed ornare vitae, pretium vitae risus.

OBJECTIVES

- Use brief sentences and
- bullets to convey your
- Objectives.
- Maecenas eleifend leo sed
- Phasellus eget velit massa.

METHODS

Again, the fewer words you can use, the better. Class aptent taciti sociosqu ad litora torquent per conubia nostra, per inceptos himenaeos.

Maecenas dui sem, mattis non scelerisque a, elementum a nibh. Morbi facilisis lacus eu nunc faucibus suscipit.

RESULTS

Here you can place graphs or images to illustrate your findings.

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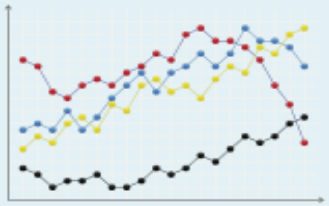

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Description Ut placerat rutrum justo, vel porta massa volutpat vel. Sed vel metus erat, lacinia gravida nibh.

MAJOR THEMES

1. Some key points you want your audience to know.
2. This could also be a place to include quotes from your qualitative research.
3. What's Next: You might point to where the research could go in the future.
4. Duis nec leo eget purus congue malesuada

SPONSORS

295

Effectiveness of a Daily Verbal Reminder to Decrease the Duration of Indwelling Urinary Catheter Use

Mount Sinai Hospital

Logan Felix, MD, Barbara Smith, RN, BSN, MPA, CIC, Eloisa Santos, RN, BSN, MA, MEd, CIC, Angela Gabasan, RN, BSN, MSN, CIC, Olena Dzenkevych, MS, Ismini Kourouni, MD and Robert S. Klein, MD, FIDSA; Division of Infectious Diseases and Infection Control, Mount Sinai St. Luke's Hospital and Mount Sinai Roosevelt Hospital, Icahn School of Medicine at Mount Sinai, New York, NY

Contact Person: Logan Felix, M.D.
E-mail: loganfelix.md@gmail.com
Tel. #: +1-212-523-2525

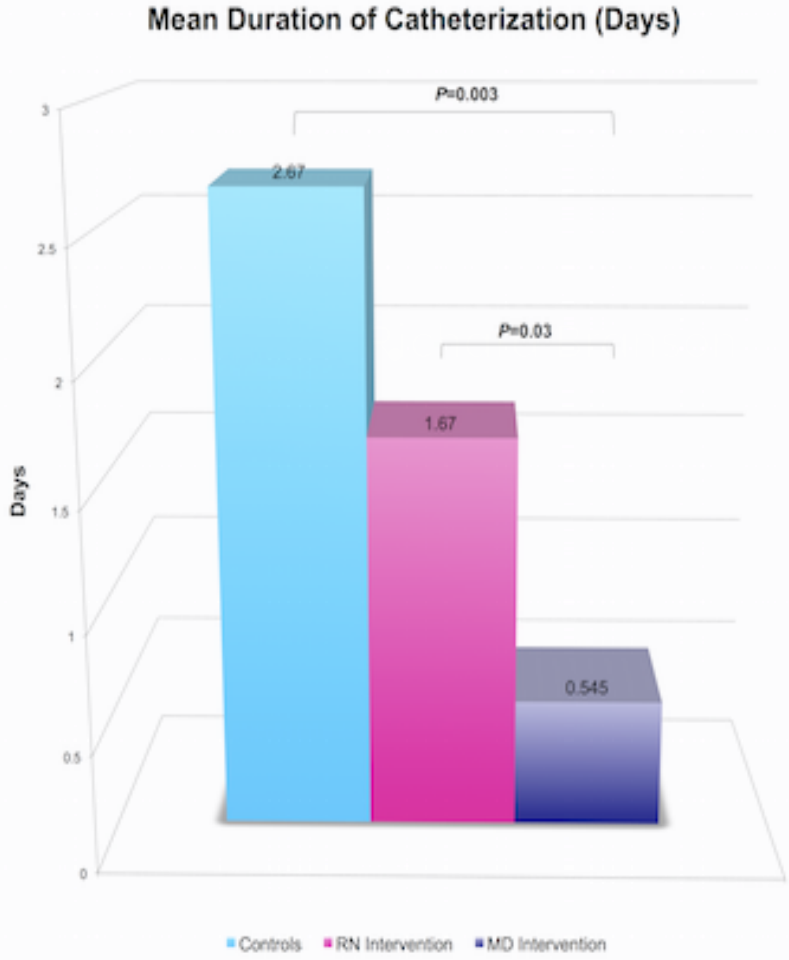
Background

- Reminders to clinicians regarding urinary catheter removal have been effective in reducing the rate of catheter-associated urinary tract infections (CAUTI). Both nurse-initiated and physician-initiated verbal reminders have shown significantly decreased duration of catheterization and rates of CAUTI but previously have not been compared directly.
- We initiated as a quality improvement project in two New York City hospitals, a comparison of nurse-initiated witth physician-initiated daily verbal reminders to remove unnecessary urinary catheters.

Methods

- At two hospitals in New York City from May 1 to June 6, 2014, patients on the medical service (excluding ICUs) who had an indwelling urinary catheter were identified daily and alternately assigned to an MD or nurse intervention group. Patients who had documentation of appropriate indications for catheter use were excluded.
- An MD or infection-control nurse contacted the medical team daily until catheter removal or hospital discharge and questioned the need for continued catheter use. Controls were patients for whom no care provider was contacted.
- Catheterization duration for the intervention groups was duration days of catheterization after intervention and for controls it was total duration minus the average duration between insertion and intervention in the intervention groups.
- Durations of catheterization were compared between groups.

Results



- 22 patients were assigned to the MD group, 21 to the RN group, and 11 to the control group. Sixty-nine percent of patients were female and 81% were >64 years old. There were no differences in demographics between groups.
- Post-intervention catheter mean (±SD) duration in the MD group was 0.545 ± 0.80 days compared both to controls at 2.67 ± 3.23 days (P=0.003) and to the RN group at 1.67 ± 2.74 days (P=0.03). There was a trend towards a decrease in post-intervention catheter days comparing the RN group to controls, but it did not reach statistical significance (P=0.12).

Conclusion

- Daily verbal reminders are a useful adjunct in reducing unnecessary urinary catheter use. This study showed that the duration of catheter use was significantly decreased if an MD performed the reminder compared to an infection control nurse. Further studies are needed to determine the cost-effectiveness of this approach in preventing CAUTIs.

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Surgeons' Acceptance of Surgical Site Infection Risk Adjustment Models

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Background

- CDC/NHSN have developed risk stratification models based on known risk factors for SSI (e.g. higher ASA score, wound class, procedure duration) to predict the rate of SSI in high-risk and low-risk procedures
- Standardized infection ratio (SIR) = observed SSI rate / predicted SSI rate

Purpose

- To assess surgeons' acceptance of current risk stratification models
- To determine what risk factors surgeons deem important for future model development

Methods

Design: Focus group

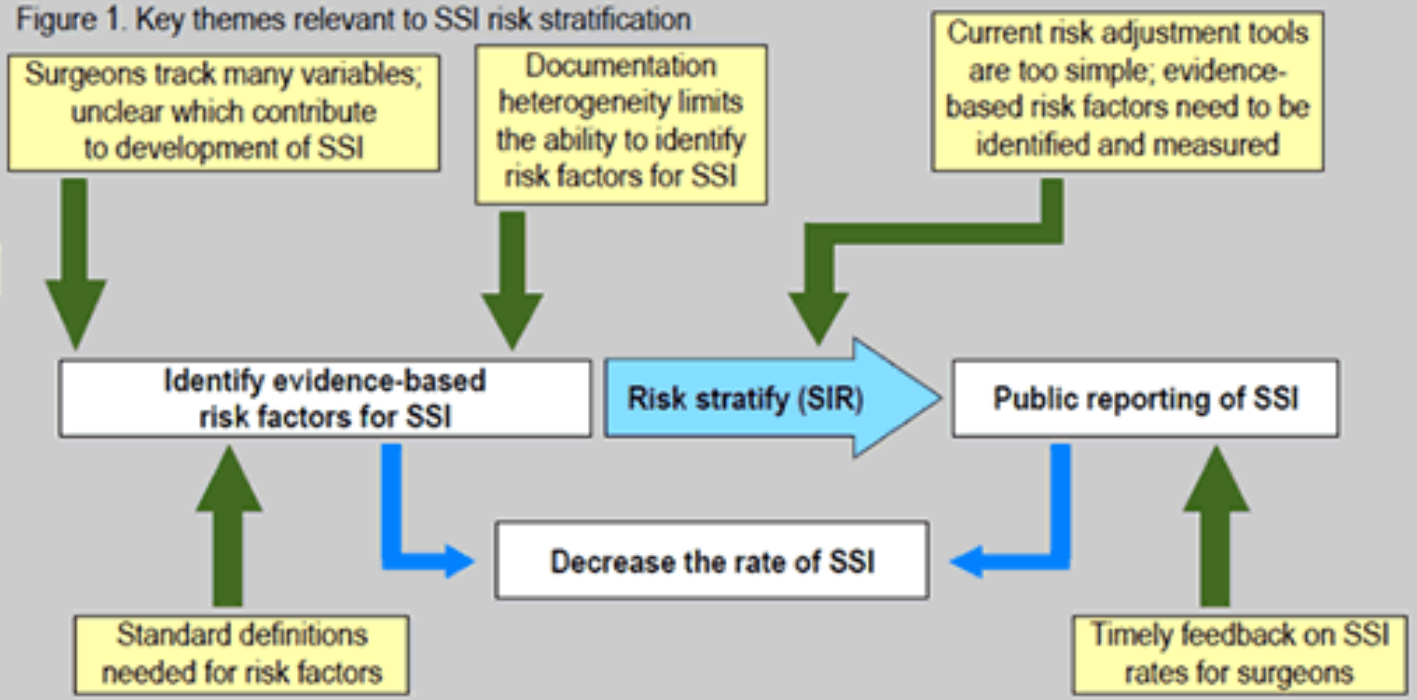
Participants: Six surgeons with research interests in SSI, representing multiple health system types (4 academic, 2 private, 2 safety net, 1 VA) and surgical specialties (5 general, 2 trauma/critical care, 1 surgical oncology)

Data collection: Audio recordings, transcribed notes, documented observations by researchers during focus group

Analysis: Inductive content analysis with open heuristic coding

Results

Figure 1. Key themes relevant to SSI risk stratification



Conclusions

- Surgeons feel that current risk adjustment models are inadequate; more refined models may improve acceptance of data and benchmarks
- Provider feedback regarding SSI rates and benchmark success rates needs to be timely
- Further research to identify evidence-based risk factors for SSI is needed

Human Metapneumovirus Infection in a Children's Hospital – Should We Pay More Attention?

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Abstract

Background
Viral respiratory infections are a major cause of hospitalization and Intensive Care Unit (ICU) admission. At childrens' hospitals, Infection Prevention closely tracks Respiratory Syncytial Virus (RSV) and Influenza, including rates of healthcare associated infections (HAI). There is conflicting data on the contribution of human Metapneumovirus (hMPV) infections to respiratory morbidity in hospitalized children.

Methods
hMPV testing was added in the 2013-14 winter viral season (D3 Ultra DFA Respiratory Virus Screening & ID Kit; Diagnostic Hybrids). Hospitalization rates, ICU admission and HAI rates were prospectively monitored and compared to current and past seasons of RSV and Influenza. Clinical information was extracted retrospectively on those patients with hMPV and RSV requiring ICU admission.

Results
For children who underwent viral respiratory testing at our facility, rates of hospitalization, ICU admission and HAIs for hMPV were comparable to or exceeded those of RSV and Influenza for the current and past 3 winter seasons (Figures 2, 3 & 4). Of 19 patients with hMPV requiring ICU admission, the average age was 6 years (y) 5 months (m) (range 8 m – 21 y 7 m), compared with an average age of 1 y 8 m (range 0 m – 15 y 4 m) for 35 ICU admitted RSV patients ($p<0.05$). Of hMPV infected patients, 16/19 (84%) had underlying medical diagnoses, including chronic lung disease in 10 (53%), and tracheostomy in 8 (42%). Six (32%) required mechanical ventilation. Only 12/35 (34%) RSV ICU admitted patients had underlying medical diagnoses; none had tracheostomies, 5 (14%) had chronic lung disease, 13 (37%) required mechanical ventilation. Length of hospitalization averaged 9.9 days (range 2-34 days) for hMPV and 7.7 days (range 1 – 25 days) for RSV ICU admits. Total contact isolation days were not significantly higher this season, likely due to a milder RSV season.

Conclusions
Among children tested for winter viral pathogens in 2013-14, hMPV rates of hospital admission, ICU admission and HAIs met or exceeded those for RSV and Influenza. ICU admitted patients with hMPV were older than those with RSV. There were more ICU admissions in hMPV patients with tracheostomy and chronic lung disease. Future efforts at surveillance and vaccine development should target this population.

Background

Viral respiratory infections are a major cause of hospitalization and Intensive Care Unit (ICU) admission. At childrens' hospitals, Infection Prevention closely tracks Respiratory Syncytial Virus (RSV) and Influenza, including rates of healthcare associated infections (HAI). There is conflicting data on the contribution of human Metapneumovirus (hMPV) infections to respiratory morbidity in hospitalized children.

Methods

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Results

Human Metapneumovirus peaked at a similar time consistent with other winter respiratory viruses (Figure 1). For children who underwent viral respiratory testing at our facility, rates of hospitalization, ICU admission and HAIs for hMPV were comparable to or exceeded those of RSV and Influenza for the current and past 3 winter seasons (Figures 2, 3 & 4). Intensive care unit admitted patients with hMPV compared to RSV were older ($p < 0.05$), and more likely to have underlying medical diagnosis, chronic lung disease or tracheostomy. Rates of mechanical ventilation and length of hospitalization were similar between the two groups (Table 1). There were no deaths due to winter viral respiratory pathogens during this time frame.
Total contact isolation days were not significantly higher this season, likely due to a milder RSV season (Figure 5).

Figure 1. Trends of Winter Viruses
October 1, 2013 – April 30, 2014

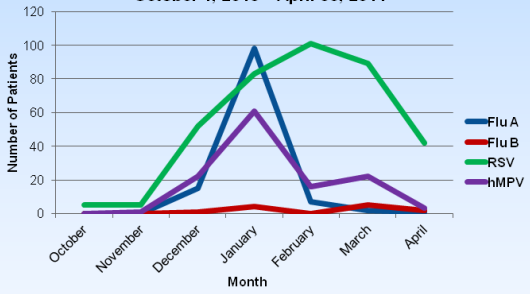
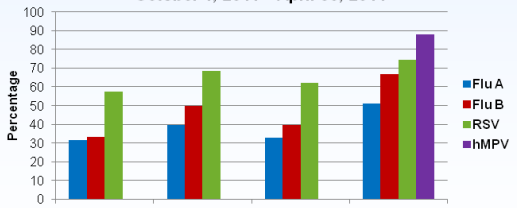


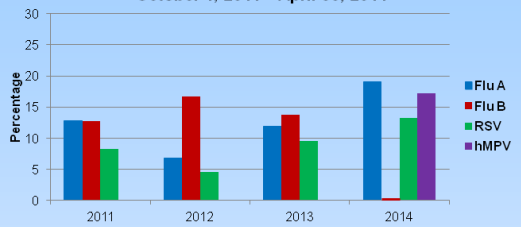
Figure 2. Winter Viral Patients Requiring Admission
October 1, 2011 – April 30, 2014



	2011 (n)	2012 (n)	2013 (n)	2014 (n)
Flu A	47	44	59	63
Flu B	47	6	58	8
RSV	602	286	463	280
hMPV	ND	ND	ND	110

ND = Not Done

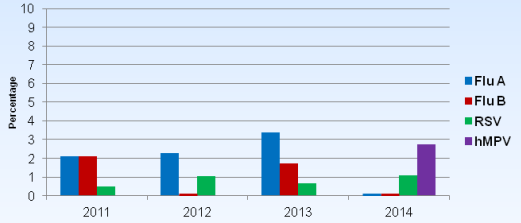
Figure 3. Winter Viral Patients Admitted to PICU/CVICU/NICU
October 1, 2011 – April 30, 2014



	2011 (n)	2012 (n)	2013 (n)	2014 (n)
Flu A	6	3	7	12
Flu B	6	1	8	0
RSV	50	13	44	35
hMPV	ND	ND	ND	19

ND = Not Done

Figure 4. Winter Viral Patients with Healthcare Acquired Infection
October 1, 2011 – April 30, 2014



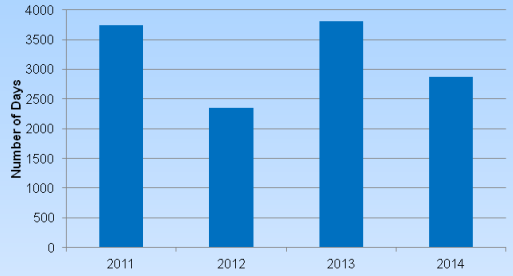
	2011 (n)	2012 (n)	2013 (n)	2014 (n)
Flu A	1	1	2	0
Flu B	1	0	1	0
RSV	3	3	3	3
hMPV	ND	ND	ND	3

ND = Not Done

Table 1. Characteristics of ICU Patients with hMPV and RSV
October 1, 2011 – April 30, 2014

	Age (y=years, m=months) Average (Range)	Underlying Medical Diagnosis	Chronic Lung Disease	Tracheostomy	Mechanical Ventilation	Length of Hospitalization (d=days) Average (Range)
hMPV	6y5m (8m-21y7m)	16/19 (84%)	10/19 (53%)	8/19 (42%)	6/19 (32%)	9.9d (2-34d)
RSV	1y8m (0m-15y4m)	12/35 (34%)	5/35 (14%)	0	13/35 (37%)	7.7d (1-25d)

Figure 5. Contact Isolation Days
October 1, 2011 – April 30, 2014



Conclusions

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Nothing to Disclose

Summary Timeline

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Thank you

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