Figure 1. Number of Patients Screened by Admission Source

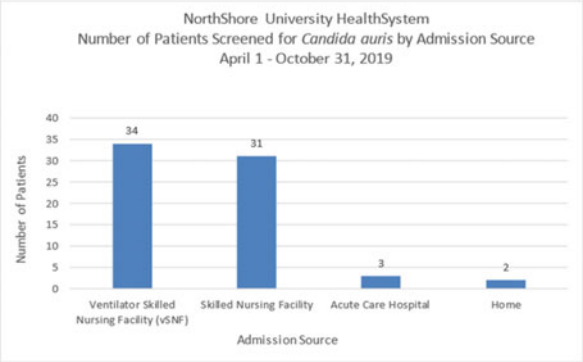

Fig. 1.

Table 1.

Table 1. Characteristics and Findings from Medical Record Review and XDRO Registry Query for *Candida auris* and Carbapenemase-Producing Organisms

Findings and Characteristics of Patients Screened	Results
Tracheostomy and/or Mechanical Ventilation at Admission n/N (%)	14/70 (20)
CA XDRO Registry Entry n/N (%)	0/70 (0)
CPO XDRO Registry Entry n/N (%)	9/70 (13)
Trach/Vent Patient with CPO XDRO Registry Entry	7/70 (10)
Known CPO by Medical Record Review n/N (%)	11/70 (16)

all ICU LTACH or vSNF admissions. Composite swabs are cultured on Inhibitory Mold Agar. In July 2019, an ICU clinical case of *C. auris* was identified from a ventilated patient admitted from an outside hospital prompting the expansion of screening to include acute-care hospital transfers. To evaluate the value of screening criteria, a medical record review and retrospective query of the XDRO Registry was performed for all screened patients. Because cocolonization with carbapenemase-producing organisms (CPO) has been reported, CPO status was also queried. **Results:** Between April 1 and October 31, 2019, 70 patients were screened. Two screened patients did not meet the screening criteria (Fig. 1). No patients, with the exception of the clinical case, were found to be colonized with CA. The XDRO Registry query identified no patients with *C. auris*. Of the 70 patients, 9 (13%) had a CPO. Of those screened, 14 (20%) had a tracheostomy and/or mechanical ventilation (Table 1). **Conclusions:** Querying the XDRO registry at admission in combination with a medical record review appears adequate to identify patients admitted to a NSUHS ICU with *C. auris* and CPOs. Targeting patients admitted with a tracheostomy and/or mechanical ventilation may further reduce the number of screening cultures performed.

Funding: None
Disclosures: None
Doi:10.1017/ice.2020.1044

Presentation Type:
Poster Presentation

Survey for "iCarePATH": Improving Caregivers' Perceptions and Attitudes Towards Hand Washing

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Background: Hand hygiene (HH) is the most effective means of preventing healthcare-associated infections (HAI). HH improvement strategies primarily focus on healthcare staff, often overlooking the significant contribution of caregivers to HAI risk. We sought to understand caregivers' HH knowledge and practices to identify improvement opportunities. **Methods:** A self-administered survey was developed and distributed to families from June to August 2019; open-ended questions and Likert scales assessed caregivers' perceptions and practices regarding HH at home and in hospital. HH compliance audits of caregivers entering and exiting inpatient rooms were performed in the same time period. **Results:** Among 81 caregivers surveyed, median patient age was 4.0 (IQR, 0.9–13.0) years. This was the first admission for 42 patients (53.8%). During this admission, 22 (27.2%) patients had been admitted for ≤1 day and 45 (55.6%) for >3 days. Caregivers reported good knowledge of HH practice, with strongly positive responses to knowledge of HH moments (94%) and proper technique (96%). Caregivers recognized that HH is required of hospital visitors (96%) to protect others (99%) and prevent illness in hospital (93%). Responses were less consistent for performing HH before entering a hospital room (83%), after exiting the room (70%), or after coughing or sneezing (65%). The attitudes of caregivers of children above 2 years were equivocal regarding expectations of their child to wash hands upon entering (40%), or exiting (41%) the hospital room. Multivariable modeling identified higher self-reported HH compliance in caregivers during first admission to hospital, compared to subsequent admissions (OR, 3.15; 95% CI, 1.11–9.65). Reported barriers to HH included hand irritation (27.2%) and perceived HH frequency (18.5%). At the time of survey completion, 62 caregivers (77%) reported not having received HH information during their child's admission from a healthcare provider or volunteer. Information was most commonly gained from posters (75%) and information in the room (31%). Most caregivers (58.0%) reported that they would prefer to receive HH information in the first 24 hours of admission. Among 200 audits, overall caregiver compliance with HH was 9%; HH before entering the room was 7.2% compared to 11.2% after exiting ($P = .33$). **Conclusions:** Reported caregiver knowledge of HH was not reflected in audited practice. Fewer than 1 in 4 had received HH information from healthcare staff. HH education in the hospital environment within the first day of admission provides an opportunity for caregivers to improve compliance as partners in HAI prevention and safer pediatric care.

Funding: None
Disclosures: None
Doi:10.1017/ice.2020.1045

Presentation Type:
Poster Presentation

Surviving and Thriving Immediate Jeopardy in Infection Control from the Centers for Medicare and Medicaid

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Background: Because of a patient death from a blood transfusion, a large hospital in Houston, Texas, underwent one of the largest unannounced CMS surveys in 2019. **Methods:** A 520-bed quaternary-care hospital was surveyed in one of the nation's largest CMS surveys in March 2019, with a resurvey in June 2019. In an anticipated but

unannounced arrival, ~30 CMS surveyors evaluated the hospital and 10 Clinical Laboratory Improvement Amendments surveyors looked at the laboratory. They stayed for 11 consecutive days in March. On day 4, they declared that the hospital was in immediate jeopardy in infection control for the same observations noted by several surveyors. In addition, 11 CMS surveyors returned for a shorter resurvey in June. **Results:** The following 14 issues were listed under the infection control heading during the first survey, which led to the immediate jeopardy designation. The hospital's infection prevention department committed to putting remediation processes, procedures, and audits in place during the first survey, which led to lifting the IJ before the surveyors left. The following shortcomings were recorded:

(1) Inappropriate donning and doffing of personal protective equipment (PPE) for patients in isolation
    Standardized donning and doffing processes of PPE developed to include train-the-trainer and return demonstrations from >4,000 employees and providers followed by a minimum of fifty (50) audits/week with the goal of achieving 100% proper PPE donning and doffing for a minimum of three months, followed by a minimum of fifty (50) quarterly observations.
(2) Environment Service (EVS) cleaning issues in isolation rooms
    Two-person isolation room cleaning process developed, implemented, and audited a minimum of ten (10) times/week.
(3) Incorrect set-up of dialysis machines
    Minimum of five (5) dialysis machine set-ups audited/week.
(4) Biohazard trash left in dialysis room between patients
    Minimum random audits twice/week to look for biohazard trash.
(5) Need for maintenance and cleanliness in the operating rooms (OR)
    Minimum three times/week audits of rotating ORs in all locations.
(6) Rust noted on OR equipment
    Minimum of twice/week audits looking for rust on OR equipment.
(7) Insects noted in OR
    Observations for living insects will be audited twice/week.
(8) Improper cleaning and high-level disinfection (HLD) of transvaginal probes
    Minimum of three times/week, cleaning and HLD processes of probes will be observed.
(9) Matching patient to probes in their medical records needed clarification
    Minimum of twice/week, logs will be audited to check that appropriate patient/probe linkage occurs.
(10) Contaminated gloves used on a blood bag in ambulatory setting
    Once/month, removal of blood bag from transport container will be observed to observe clean/dirty glove use
(11) Lack of cleaning between patients of durable medical equipment
    Cleaning of DME will be observed for thoroughness a minimum of three times/week.
(12) Sanitation and mislabeling issues in the kitchen
    A minimum of one (1) complete audit and two (2) abbreviated audits of kitchen sanitation and food labeling will be conducted per week.
(13) Endoscopy misuse of test strips
    Test strip audits showing appropriate labeling and use will be auditing a minimum of twice/week.
(14) Process of air blowing of automatic endoscopic reprocessor (AER) needed improvement.
    A minimum of two air blows during the AER process implemented and audited for a minimum of once/week.

In addition, 2 additional full-time equivalents (FTEs) in infection prevention were hired as a result of the survey to assure appropriate staffing to continue evaluations of these issues. Staffing went from 7 FTE in infection prevention, for a staffing ratio of 1 IP FTE per 74 occupied beds, to 9 FTEs, for a ratio of 1 IP FTE per 58 occupied beds. **Conclusions:** Committing to ongoing audits to address processes and procedures led to CMS removal of the immediate jeopardy label and improvements in infection prevention were achieved. The CMS was returned to the hospital to standard status. Improvements have been sustained, and the focus on infection prevention continues to assist in the prevention of healthcare-associated infections in both inpatients and outpatients, thereby improving patient safety.

Funding: None
Disclosures: None
Doi:10.1017/ice.2020.1046

Presentation Type:
Poster Presentation

Targeted Assessment for Prevention: A Statewide Collaborative

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Background: Infection preventionists (IPs) are the backbone of the quality and safety matrix of their organizations. Tools to help locate potential gaps can provide unique viewpoints from frontline staff. The CDC provides a Targeted Assessment for Prevention (TAP) strategy that identifies vulnerabilities in the prevention of healthcare-associated infection (HAIs). **Methods:** A statewide quality improvement organization, partnering with the CDC TAP team, administered TAP facility assessments for catheter-associated urinary tract infection (CAUTI), central-line–associated bloodstream infection (CLABSI), and *Clostridioides difficile* infection (CDI) to a collaborative of 15 acute-care and 2 long-term acute hospitals. More than 800 respondents filled out surveys based on their individualized perceptions of infection prevention practices. **Results:** The survey results yielded the following lagging indicators: lack of awareness of nursing and physician champions, need for competency-based training of clinical equipment, and feedback on device utilization. At the hospital system level, one improvement team focused on CDI, uncovered leading and lagging areas in general infrastructure, antibiotic stewardship, early detection and appropriate testing, contact precautions, and environmental cleaning. To culminate the TAP collaborative, the cohort of organizations, supported by interdisciplinary teams, participated in a full-day TAP workshop in which they reviewed detailed analyses of their HAI data and assessment results, shared best practices for infection prevention and planned for specific improvement projects using the plan-do-study-act model. **Conclusions:** Results of a statewide analysis of HAI prevention data and opportunities at a local level were reviewed. The TAP strategy can be used to target opportunities for improvement, to assess gaps in practice, and to develop and implement interventions for improving outcomes. Healthcare facilities and quality improvement organizations can drive infection prevention actions.

Funding: None
Disclosures: None
Doi:10.1017/ice.2020.1047