

- Audit and reward compliance with UV light utilization, environmental cleaning Reduce shared patient care equipment, replace with disposable items
- Provide products for patient hand hygiene
- Implement marketing campaign to tie elements together
- **Control**
- Audit compliance with testing and isolation policies
- Laboratory rejection of formed stools
- Audit cleaning processes with adenosine triphosphate (ATP) monitor
- Track ultraviolet light usage

Collaborate with the antibiotic stewardship committee to audit and adjust prescribing practices as needed. **Results:** HO CDI cases decreased by 48% from 2017 to 2018. The NHSN SIR decreased below 1.0. **Conclusions:** The CDIFFerently initiative was successful as a bundled approach to CDI reduction. Incorporating program elements aimed at addressing diagnostic stewardship, antimicrobial stewardship, environmental contamination, transmission prevention and ongoing education, and tying them together with a successful marketing campaign, allowed staff to connect individual actions with a “big picture” approach to HAI reduction.

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Cerebrospinal Fluid Shunt-Associated Surgical Site Infection With Three- Versus Twelve-Month Follow-Up in Canadian Hospitals

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Background: Surgical site infection (SSI) after cerebrospinal fluids (CSF) shunt surgery is thought to be acquired intraoperatively. Biomaterial-associated infection can present up to 1 year after surgery, but many national systems have shortened follow-up to 90 days. We compared 3- versus 12-month follow-up periods to determine the nature of case ascertainment in the 2 periods. **Methods:** Participants of any age with placement of an internal CSF shunt or revision surgical manipulation of an existing internal shunt identified in the Canadian Nosocomial Infection Surveillance Program (CNISP) participating hospitals between 2006 and 2018 were eligible. We excluded patients with external shunting devices or culture-positive CSF at the time of surgery. Patients were followed for 12 months after surgery for the primary outcome of a CSF infection with a positive CSF culture by review of laboratory and health records. Patients were categorized as adult (aged ≥ 18 years) or pediatric (aged < 18 years). The infection rate was expressed as the number of CSF shunt-associated infections divided by the number of shunt surgeries per 100 procedures. **Results:** In total, 325 patients (53% female) met inclusion criteria

Figure: Number and percentage of CSF-SSI identified by week post shunt surgery

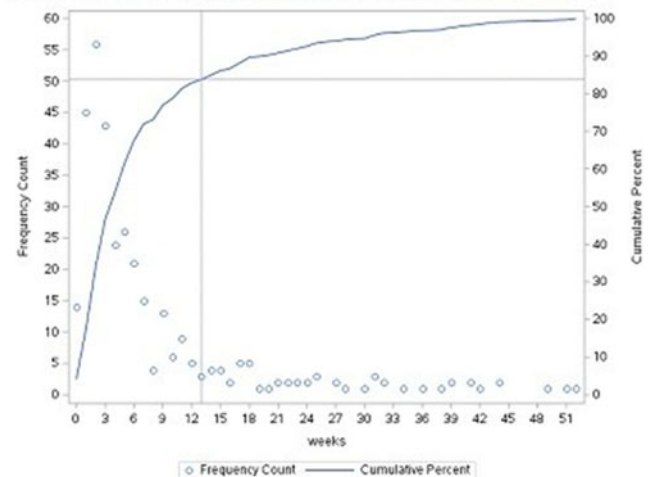


Fig. 1.

in 14 hospitals from 7 provinces were identified. Overall, 46.1% of surgeries were shunt revisions and 90.3% of shunts were ventriculo-peritoneal. For pediatric patients, the median age was 0.7 years (IQR, 0.2–7.0). For adult patients, the median age was 47.9 years (IQR, 29.6–64.6). The SSI rates per 100 procedures were 3.69 for adults and 3.65 for pediatrics. The overall SSI rates per 100 procedures at 3 and 12 months were 2.74 ($n = 265$) and 3.48 ($n = 323$), respectively. By 3 months (90 days), 82% of infection cases were identified (Fig. 1). The median time from procedure to SSI detection was 30 days (IQR, 10–65). No difference was found in the microbiology of the shunt infections at 3- and 12-month follow-ups. The most common pathogens were coagulase-negative *Staphylococcus* (43.6%), followed by *S. aureus* (24.8%) and *Propionibacterium* spp (6.5%). No differences in age distribution, gender, surgery type (new or revision), shunt type, or infecting organisms were observed when 3- and 12-month periods were compared. **Conclusions:** CSF-SSI surveillance for 3 versus 12 months would capture 82.0% (95% CI, 77.5–86.0) of cases, with no significant differences in the patient characteristics, surgery types, or pathogens. A 3-month follow-up can reduce resources and allow for more timely reporting of infection rates.

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Challenges and Facilitators to Effective Infection Prevention in Home Health Care: Results From Qualitative Interviews of Home Health Care Services

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Background: As the population of older Americans with chronic conditions continues to grow, the role of home health care (HHC) services in improving care transitions between acute care and independent living has become a national priority. Infection prevention and control (IPC) is often a focus of quality improvement initiatives