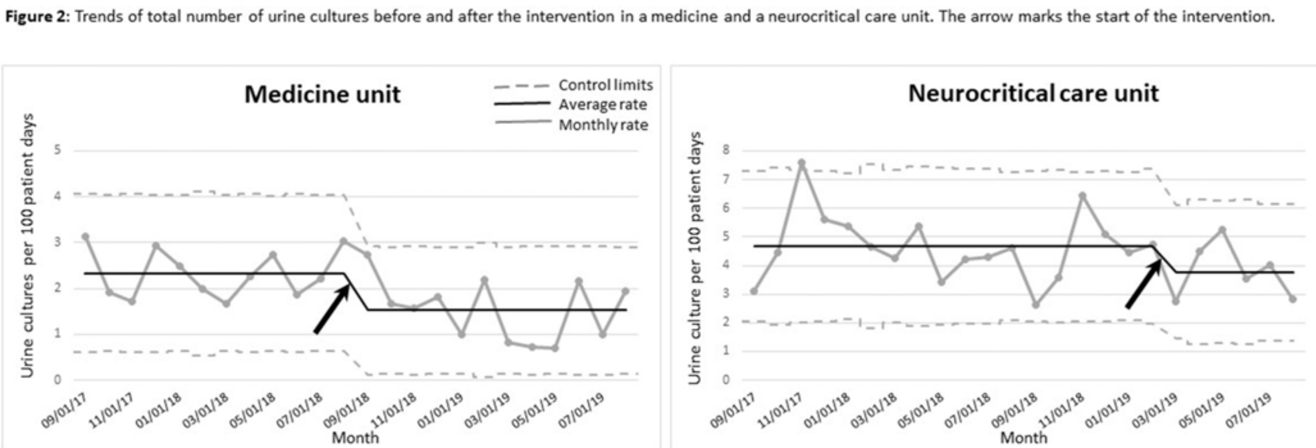

Fig. 2.

unnecessary urine cultures. Nurses received in-person training by an ASP physician champion on how to use the algorithm and education on the definition and indications for evaluation for asymptomatic bacteriuria and urinary tract infections. The ASP physician periodically visited the units to address concerns and questions. In both units, a nurse champion was identified to serve as liaison between the ASP and bedside nurses, and physician support was obtained before the intervention. The pre- and postintervention periods for the medicine unit were September 2017–August 2018 and September 2018–August 2019, respectively. For the NCCU, these periods were September 2018–February 2019 and March 2019–September 2019, respectively. Trends in urine cultures per 100 patient days (PD) were examined with statistical process charts and compared before and after the intervention using a standard incident ratio (IRR) and Poisson regression. **Results:** In total, 327 urine cultures were collected in the medicine unit and 293 in the NCCU over the study period. Although the intervention led to a significant 34% reduction in the rate of urine cultures on the medicine unit (from 2.3 to 1.5 cultures/100 PD; IRR, 0.66; 95% CI, 0.50–0.87; $P <$ .01), the number of urine cultures remained without a significant change in the NCCU (from 4.5 to 3.7 cultures/100 PD; IRR, 0.89; 95% CI, 0.65–1.22; $P = .48$) (Fig. 2). **Conclusions:** Algorithm-based, nurse-driven review of urine culture indications reduced urine cultures on a medicine unit but not in a neurosciences ICU. Success on the medicine unit may have been driven by highly engaged nurse and physician champions and by patients being able to respond questions about symptoms. The following factors might have impacted results on NCCU: presence of conflicting protocols (eg, panculturing patients every 48 hours per a hypothermia protocol), unit tradition (eg, obtaining cultures to assess treatment response), perception of greater risk benefit in NCCU patients, and unit dynamics (open unit with other primary services placing orders for patients). Unit and team dynamics can affect effective implementation of antimicrobial stewardship interventions by nurses.

Funding: None
Disclosures: None
Doi:10.1017/ice.2020.845

Presentation Type:
Poster Presentation

Implementation of Hospital-Based *Candida auris* Surveillance Screening Among At-Risk Patients

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Background: *Candida auris* is an emerging multidrug-resistant pathogen associated with outbreaks in hospitals and skilled nursing facilities (SNFs). Patients with *C. auris* can have invasive disease or asymptomatic colonization. Because *C. auris* can be difficult to treat and eradicate in the environment, the CDC

Source	Pre-Decontamination		Post-Decontamination #1		Post-Decontamination #2	
	Qualitative Result	CA Ct	Qualitative Result	CA Ct	Qualitative Result	CA Ct
Enteral feeding pump	Indeterminate	39.1	Negative	0	NP*	NP
Keyboard Mouse/Medication Scanner	Negative	0	Negative	0	NP	NP
Bedrail	Negative	0	Positive	36.7	Positive	33.1
Nebulizer	Indeterminate	38.2	Negative	0	NP	NP
Ventilator	Indeterminate	39.7	Negative	0	NP	NP
Vitals Machine	Positive	36.4	Negative	0	NP	NP
Bedside Table	Negative	0	Negative	0	NP	NP
Bedside monitor	Positive	36.7	Indeterminate	39.1	Positive	36.5

*NP:Not performed.

Fig. 1.

recommends using contact precautions and sporicidal agents during patient care. After *C. auris* was identified in a patient from an LA County SNF (SNF-X), our institution initiated surveillance screening on high-risk patients. **Methods:** Nurses identified patients residing at SNF-X on admission and contacted infection prevention. These patients were placed on contact or spore precautions. Bilateral axilla and inguinal folds were swabbed with an Eswab and sent for testing by a clinical laboratory-developed RT PCR assay, which can detect *C. auris* with high sensitivity and specificity with a rapid turnaround time (4–6 hours). This PCR assay was based on a commercial platform IntegratedCycler (Diasorin) and reagents from the same vendor. Environmental swabs from the index patient's room were sent for PCR by HardyCHROM *Candida* agar (Hardy Diagnostics) before and after cleaning with OxyCideTM. PCR-positive samples were set up for culture. **Results:** In total, 27 patients from SNF-X were screened by PCR. Of these patients, 15 (55%) had a tracheostomy present on admission. Moreover, 26 swabs were negative; 1 was positive in the index patient (cycle threshold [Ct] value, 26). Clinical specimens from the index patient's blood did not grow *C. auris*; the tracheostomy sample grew predominantly *C. albicans* which made identification of *C. auris* challenging by culture. However, investigational testing of this sample by PCR was positive (Ct value, 31). Environmental swabs collected from the patient room were obtained before and after cleaning (Table 1); all environmental cultures were negative at 5 days. **Conclusions:** Developing hospital-based, high-risk patient screening for *C. auris* is feasible and may be useful for controlling the spread of *C. auris* within the community. Further study is needed to determine the usefulness of PCR for environmental testing to assess the risk of nosocomial transmission of *C. auris*.

Funding: None
Disclosures: None
Doi:10.1017/ice.2020.846

Presentation Type:
Poster Presentation

Implementation of Rapid Molecular Diagnostic Tests and Antimicrobial Stewardship Involvement in Acute-Care Hospitals

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Background: In recent years, several rapid molecular diagnostic tests (RMDTs) for infectious diseases diagnostics, such as bloodstream infections (BSIs), have become available for clinical use. The extent to which RMDTs have been adopted and how the results of these tests have been incorporated into clinical care are currently unknown. **Methods:** We surveyed members of the Society for Healthcare Epidemiology of America Research Network to characterize utilization of RMDT in hospitals and antimicrobial stewardship program (ASP) involvement in result communication and interpretation. The survey was administered using Qualtrics software, and data were analyzed using Stata and Excel software. **Results:** Overall, 57 responses were received (response rate, 59%), and 72% were from academic hospitals; 50 hospitals (88%) used at least 1 RMDT for BSI (Fig. 1). The factors most commonly reported to have been important in the decision to adopt RMDT were improvements in antimicrobial usage (82%), clinical outcomes (74%), and laboratory efficiency (52%). Among 7 hospitals that did not use RMDT for BSI, the most common reason was cost of new technology. In 50 hospitals with RMDT for BSI, 54% provided written guidelines for optimization or de-escalation of antimicrobials based upon RMDT results. In 40 hospitals (80%), microbiology laboratories directly notified a healthcare worker

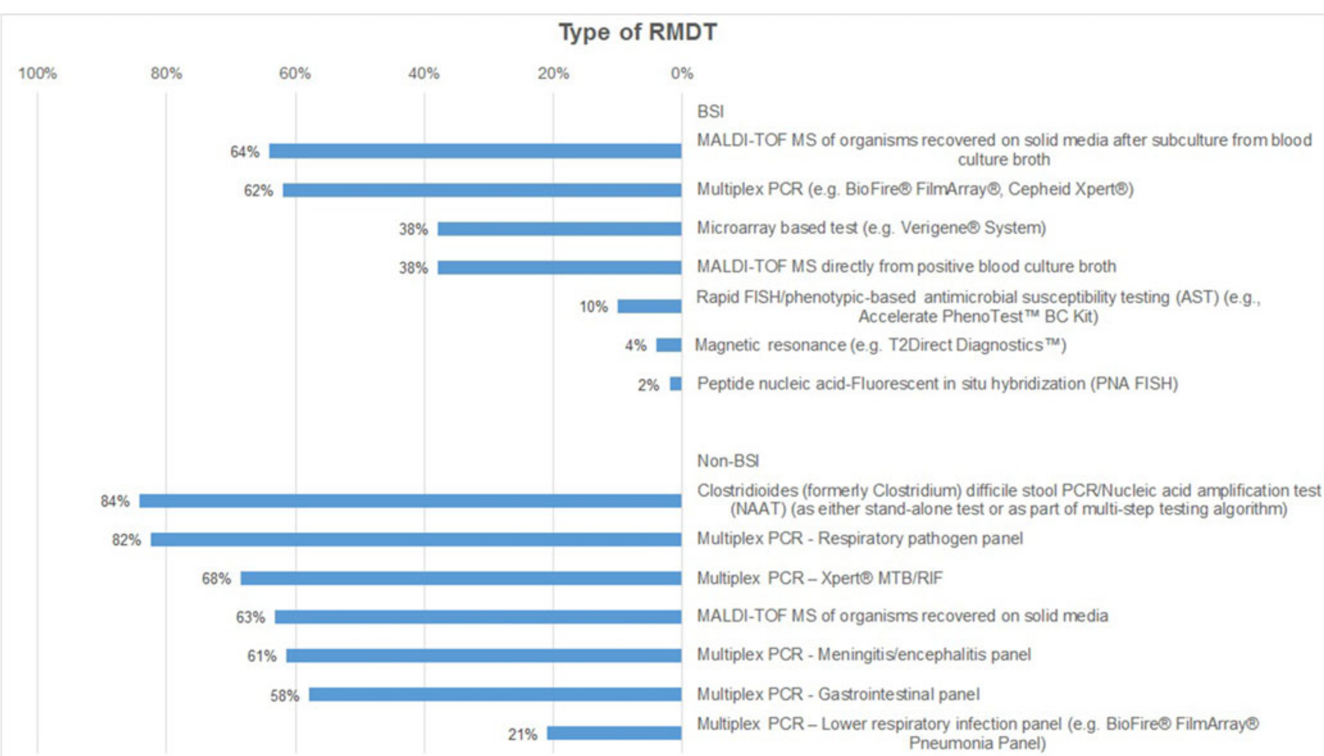

Fig. 1.