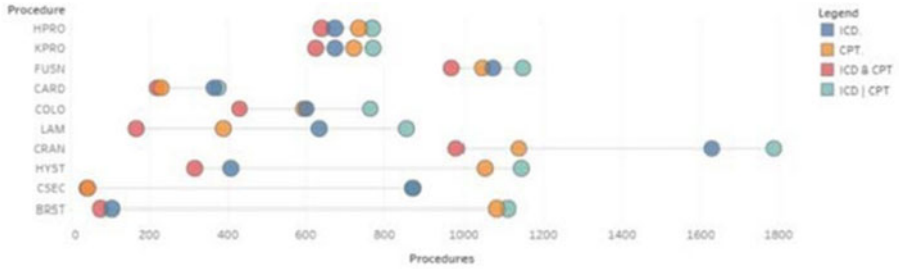

Figure 1: Abstracted procedures performed at the University of Iowa Hospitals & Clinics during one year: October 2018–September 2019. Abbreviations: COLO, colon; HYST, hysterectomy; CSEC, cesarean section; BRST, breast; CARD, cardiac; CRAN, craniotomy; FUSN, spinal fusion; LAM, laminectomy; HPRO, hip prosthesis; KPRO, knee prosthesis; ICD, International Classification of Diseases; CPT, Current procedural Terminology codes.

Fig. 1.

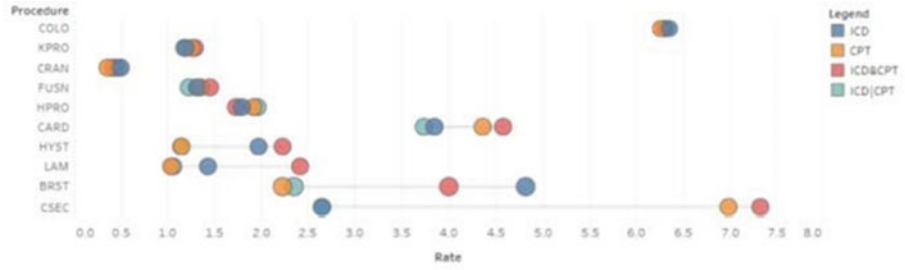

Figure 2: Surgical site infection rate variation by procedure type and coding method used. The University of Iowa Hospitals & Clinics, 2018–2019. Abbreviations: COLO, colon; HYST, hysterectomy; CSEC, cesarean section; BRST, breast; CARD, cardiac; CRAN, craniotomy; FUSN, spinal fusion; LAM, laminectomy; HPRO, hip prosthesis; KPRO, knee prosthesis; ICD, International Classification of Diseases; CPT, Current procedural Terminology codes.

Fig. 2.

whereas abdominal hysterectomy showed nearly a 2-fold increase (1.14% when using CPT only to 2.22% with both ICD & CPT codes). However, SSI rates remained fairly similar for craniotomy (0.14% absolute difference), hip prosthesis (0.24% absolute difference), and colon (0.09% absolute difference) despite differences in the number of abstracted procedures and coding methods. **Conclusions:** Denominators and SSI rates vary depending on the coding method used. Variations in the number of procedures abstracted and their subsequent impact on SSI rates were not predictable. Variations in coding methods used by hospitals could impact interhospital comparisons and benchmarking, potentially leading to disparities in public reporting and hospital penalties.
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Presentation Type:
Poster Presentation

Admission Screening for *Candida auris* Among High-Risk Patient Populations

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Background: *Candida auris* is a highly transmissible healthcare-associated pathogen that can cause severe infection as well as long-lasting colonization. *C. auris* is often resistant to the antifungals that are commonly used to treat *Candida* infections, which may lead to clinical failure. Therefore, healthcare facilities must identify the organism quickly and implement strict precautions to prevent its spread. In 2019, the NIH Clinical Center instituted *C. auris* admission screening among its high-risk patient populations. **Methods:** Patients admitted to the NIH Clinical Center, a 200-bed research hospital, were identified on admission as having been hospitalized outside the United States in the prior 6 months. Admission screening began in August 2019. In September 2019, due to evolving regional epidemiology, we expanded surveillance criteria to include patients housed in any healthcare facility in the District of Columbia, Maryland, and Virginia metro area in the previous 6 months. Screening was performed as routine clinical care, and therefore did not require written informed consent.

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Swabs were obtained from nares, axilla and groin, with subsequent addition of mouth and toe web (BD ESwabs). Patients were placed on empiric contact isolation for at least 48 hours and concurrently screened for carbapenemase-producing organisms. Swabs were cultured on CHROMagar *Candida* and in Sabouraud dextrose broth with 10% NaCL and 50 mg/L chloramphenicol and gentamicin, and incubated for 14 days at 30°C and 40°C, respectively. Positive broth tubes were subcultured onto CHROMagar *Candida*. *C. auris* was identified by MALDI-TOF MS and ITS sequence analysis. Susceptibility testing was performed using Sensititre YeastOne Colorimetric assay. Whole-genome sequencing was used to identify clonal designations and genetic relatedness of isolates. **Results:** Since August 2019, 1 to 2 patients per week have been screened for *C. auris*. As of November 2019, 1 of 15 patients screened on admission grew *C. auris* from a groin swab. The patient, who had been hospitalized abroad, was found to be cocolonized with *bla*NDM-1+ *E. coli* and *K. pneumoniae*. Subsequent screening of other patients on the same ward identified no evidence of spread. Admission surveillance is ongoing. **Conclusions:** Healthcare-associated outbreaks can originate from *C. auris*–colonized patients. Admission surveillance of high-risk patients is intended to prevent transmission from undetected reservoirs. Our sampling of multiple sites, though laborious, may add to the data on *C. auris* colonization. Future plans include incorporating molecular testing and streamlining geographic criteria. *C. auris* admission screening has already identified one colonized patient, and will continue as a new and important patient safety measure at our hospital.

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Presentation Type:
Poster Presentation

Admission Screening for *Clostridium difficile* Infection (CDI) in Bone Marrow Transplant Populations

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Background: *Clostridium difficile* infection (CDI) is the most common healthcare-associated infection (HAI) and is often associated with increased medical costs and longer lengths of hospital stay. Previous studies have highlighted that hematopoietic stem cell transplant (HSCT) recipients are at an increased risk for CDI of up to 33% from other hospitalized patients. Studies have also supported the prevalence of asymptomatic colonization with *C. difficile* among HSCT patients. Asymptomatic colonization with *C. difficile* is a significant risk factor for transmission of infection to other patients developing hospital onset (HO-CDI). Therefore, targeted infection prevention efforts, such as early identification of patients with community-onset (CO-CDI) and patients with asymptomatic colonization with CDI in HSCT patients, may be effective in reducing the occurrence of HO-CDI. We discuss the CDI admission screening protocol in Emory University Hospital's (EUH) bone marrow transplant (BMT) unit. **Methods:** As part of an infection prevention initiative, a CDI screening protocol was implemented in December 2018 for all patients that admitted to the EUH inpatient BMT unit. Upon admission, patients were screened for CO-CDI symptoms, specifically loose or unformed stools. A *C. difficile* toxin assay PCR would be collected within the first 3 calendar days of admission for all patients screened. Patients with symptoms were placed on isolation precautions pending results of the *C. difficile* toxin assay. If a patient had a positive *C. difficile* toxin assay result, isolation precautions would be maintained for the duration of hospitalization regardless of symptoms. Patients who are were unable to produce a stool specimen on the first 3 days of admission were excluded from the screening protocol. Patients with positive *C. difficile* toxin assay PCRs were classified as CO-CDI and were treated. **Results:** Since implementation of the CDI screening protocol, 109 CDI events were identified from January 2019 to October 2019. Moreover, 79% of positive *C. difficile* toxin assays were collected within the first 3 calendar days of admission. HO-CDI has decreased from 78% in 2018 to 21% during the designated time frame. **Conclusions:** CDI screening upon admission of BMT populations has shown a decrease among HO-CDI by early identification of CO-CDI and CO asymptomatic colonization with *C. difficile*. This early identification has allowed rapid implementation of infection preventions precautions, thus reducing risk of unit-based transmission.

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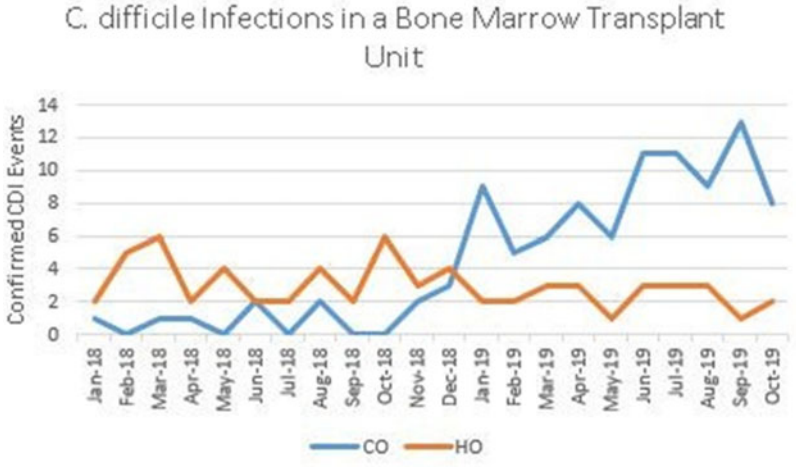

Fig. 1.

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