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

Maiko Kondo, NewYork-Presbyterian Weill Cornell Medical Center; Matthew Simon, Weill Cornell Medical College; Lars Westblade; Stephen Jenkins; Esther Babady, Memorial Sloan Kettering Cancer Center; Angela Loo, NewYork-Presbyterian/Weill Cornell Medical College; David Calfee, NY-Presbyterian/Weill Cornell

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

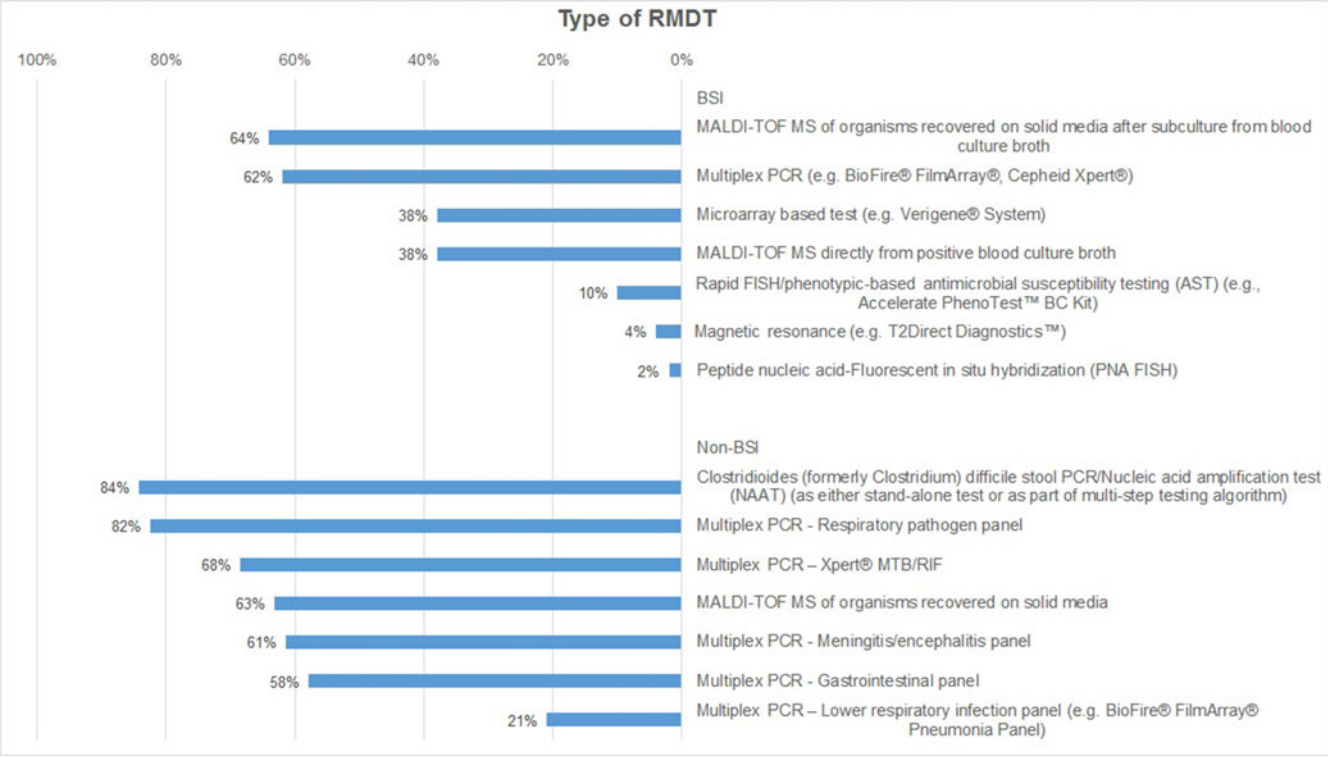

Fig. 1.

of the RMDT results: 70% provided results to a physician, nurse practitioner, or physician assistant; 48% to the ASP team; and 33% to a nurse. Furthermore, 11 hospitals (22%) had neither guidelines nor ASP intervention. In addition, 24 hospitals (48%) reported performing postimplementation evaluation of RMDT impact. Reported findings included reduction in time to antibiotic de-escalation (75%), reduction in length of stay (25%), improved laboratory efficiency (20%), and reduction in mortality and overall costs (12%). Among the 47 hospitals with both RMDT and ASP, 79% reported that the ASP team routinely reviewed blood culture RMDT results, and 53.2% used clinical decision support software to do so. Finally, 53 hospitals (93%) used 1 or more RMDT for non–bloodstream infections (Fig. 1). Fewer than half of hospitals provided written guidelines to assist clinicians in interpreting these RMDT results. **Conclusions:** RMDTs have been widely adopted by participating hospitals and are associated with positive self-reported clinical, logistic, and financial outcomes. However, nearly 1 in 4 hospitals did not have guidelines or ASP interventions to assist clinicians with optimization of antimicrobial prescribing based on RMDT results for BSI. Also, most hospitals did not have guidelines for RMDT results for non-BSI. These findings suggest that opportunities exist to further enhance the potential benefits of RMDT.

Funding: None
Disclosures: None
Doi:10.1017/ice.2020.847

Presentation Type:
Poster Presentation

Implementation of Surgical Site Infection (SSI) Gap Analysis and Data Visualization Dashboards to Drive Organizational Change

Jenna Eichelberger, SSM Health; Christine Zirges, SSM Health; Madison Himelright, SSM Health; Cara Wiskow, SSM Health

Background: Surgical site infections (SSIs) are a major healthcare quality issue; they lead to increased morbidity and mortality rates. They also prolong the length of stay and increase the cost to the patient and the healthcare system. Depending on the procedure, the risk of death is 2 to 11 times greater for patients with an SSI than for patients without an SSI. Additionally, the financial burden and patient burden is considerable; it ranks as the most common and costly of hospital-acquired infections (HAIs) and can extend a patient's length of stay by 11.2 days. The risk of developing an SSI is affected by multiple factors at the patient, operative, and institutional levels. **Methods:** A Midwestern healthcare system conducted a review of the recommended best-practice guidelines that are currently accepted as the standards of care in US healthcare facilities. A gap analysis instrument for colorectal SSI prevention was drafted and reviewed for content validity and accuracy by field experts. Hospital infection preventionists worked in conjunction with operating room leaders to disseminate the survey to staff. Responses were collected from June 5 to June 30, 2019. Concurrently, the system infection preventionist team developed a standardized SSI dashboard template that could be used at the hospital, regional, and system level to visualize SSI infection counts, standardized infection ratios (SIRs) as well as procedure count data. These dashboard reports are updated and distributed on a monthly basis to each hospital's campus executive team and other leaders. Federal- and state-required procedures were included and additional procedures were included based on hospital risk. **Results:** In total, 35 responses were recorded from 8 ministries across the system. Infection preventionists, operating room directors, physicians, nurses, and surgical technologists were represented among the respondents. The following areas were identified areas for improvement: use of chlorhexidine gluconate (CHG) bathing kit, mechanical bowel preparation with preoperative oral antibiotics, hair removal practices, use of fascial wound protector, maintenance of patients' blood glucose levels, glove and gown changing procedures, and use of antimicrobial-coated sutures. The development and distribution of the SSI dashboard increased awareness and knowledge of SSIs by hospital and system-level leaders. **Conclusions:** The implementation of both the gap analysis and dashboard reports improved the awareness areas needed for improvement and knowledge of the burden of SSIs. These findings will drive discussions within the hospitals and at the system-level to implement evidence-based practice to improve care and decrease infections as well as guide the development of SSI patient care bundles.

Funding: None
Disclosures: None
Doi:10.1017/ice.2020.848

Presentation Type:
Poster Presentation

Implementation Strategies of a Quality Improvement Initiative for Hospital-Acquired *Clostridioides difficile* Infection Prevention

Nicole Lamont, University of Calgary; Lauren Bresee, University of Calgary; Kathryn Bush, Infection Prevention & Control, Alberta Health Services; Blanda Chow, Infection Prevention & Control, Alberta Health Services; Bruce Dalton, Pharmacy Services, Alberta Health Services; Cody Doolan, University of Calgary; Peter Faris, University of Calgary; Jared Fletcher, Mount Royal University; Sara Hartman, University of Calgary; Jaime Kaufman, University of Calgary; Maida Khan, University of Calgary; Joseph Kim, Alberta Health Services/University of Calgary; Maitreyi Kothandaraman, Alberta Health Services/University of Calgary; Scott Kraft, Alberta Health Services/University of Calgary; Oscar Larios, Alberta Health Services/University of Calgary; Jenine Leal, Alberta Health Services/University of Calgary; Braden Manns, Alberta Health Services/University of Calgary; Bayan Missaghi, Alberta Health Services/University of Calgary; Wrechelle Ocampo, University of Calgary; Dylan Pillai, University of Calgary; Paule Poulin, Alberta Health Services; Deana Sabuda, Pharmacy Services, Alberta Health Services; Ye Shen, Infection Prevention & Control, Alberta Health Services; Thomas Louie, Alberta Health Services/University of Calgary; Jayna Holroyd-Leduc, Alberta Health Services/University of Calgary; John Conly, Alberta Health Services/University of Calgary

Background: *Clostridioides difficile* infection (CDI) is the most common cause of infectious diarrhea in hospitalized patients. Probiotics have been studied as a measure to prevent CDI. Timely probiotic administration to at-risk patients receiving systemic antimicrobials presents significant challenges. We sought to determine optimal implementation methods to administer probiotics to all adult inpatients aged ≥55 years receiving a course of systemic antimicrobials across an entire health region. **Methods:** Using a randomized stepped-wedge design across 4 acute-care hospitals (n = 2,490 beds), the probiotic Bio-K+ was prescribed daily to patients receiving systemic antimicrobials and was