continued for 5 days after antimicrobial discontinuation. Focus groups and interviews were conducted to identify barriers, and the implementation strategy was adapted to address the key identified barriers. The implementation strategy included clinical decision support involving a linked flag on antibiotic ordering and a 1-click order entry within the electronic medical record (EMR), provider and patient education (written/videos/in-person), and local site champions. Protocol adherence was measured by tracking the number of patients on therapeutic antimicrobials that received BioK+ based on the bedside nursing EMR medication administration records. Adherence rates were sorted by hospital and unit in 48- and 72-hour intervals with recording of percentile distribution of time (days) to receipt of the first antimicrobial. **Results:** In total, 340 education sessions with >1,800 key stakeholders occurred before and during implementation across the 4 involved hospitals. The overall adherence of probiotic ordering for wards with antimicrobial orders was 78% and 80% at 48 and 72 hours, respectively over 72 patient months. Individual hospital adherence rates varied between 77% and 80% at 48 hours and between 79% and 83% at 72 hours. Of 246,144 scheduled probiotic orders, 94% were administered at the bedside within a median of 0.61 days (75th percentile, 0.88), 0.47 days (75th percentile, 0.86), 0.71 days (75th percentile, 0.92) and 0.67 days (75th percentile, 0.93), respectively, at the 4 sites after receipt of first antimicrobial. The key themes from the focus groups emphasized the usefulness of the linked flag alert for probiotics on antibiotic ordering, the ease of the EMR 1-click order entry, and the importance of the education sessions. **Conclusions:** Electronic clinical decision support, education, and local champion support achieved a high implementation rate consistent across all sites. Use of a 1-click order entry in the EMR was considered a key component of the success of the implementation and should be considered for any implementation strategy for a stewardship initiative. Achieving high prescribing adherence allows more precision in evaluating the effectiveness of the probiotic strategy.

Funding: Partnerships for Research and Innovation in the Health System, Alberta Innovates/Health Solutions **Funding:** Award
Disclosures: None
Doi:10.1017/ice.2020.849

Presentation Type:
Poster Presentation

Implementing a Centralized Surveillance and Validation Program for Infection Prevention

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Background: Mandatory reporting of all healthcare-associated infections (HAIs) leads to substantial surveillance volume for infection prevention and control (IPC) programs. Prior to 2019, 6 infection preventionists were performing system-wide surveillance for all infection types using NHSN definitions at a large quaternary-care center in Pennsylvania. Limited surveillance validation was performed. With the continued expansion of the health system, increased demands for IPC expertise, and a growing team, the need for streamlined surveillance, and a validation program were identified. **Methods:** A surveillance training program for novice team members was developed and implemented. Infection prevention associates (IPAs), whose primary role was data management, began training. The new program included NHSN training videos, direct observation of surveillance with infection preventionists and practice case studies. Following training, IPAs performed surveillance for experienced infection preventionists covering high-risk inpatient units. To ensure high reliability, surveillance validation was initiated. Each month, ~10% of investigated infections were randomly pulled from the electronic surveillance system and divided among experienced infection preventionists. These validators performed unbiased reviews of the charts based on limited data, including patient demographics and culture results. Validation documentation included noting whether an infection was reportable to NHSN and a rationale. Data on whether or not each patient had a complex medical history and time spent validating each case were collected. Compliance of validator documentation aligning with original documentation was tracked. Discrepancies were discussed as a team and were adjudicated as needed. IPAs tracked hours spent on surveillance to capture effort transitioned from infection preventionists. **Results:** Between March and July 2019, an average of 223 (range, 178–261) potential infections were reviewed per month. From March through June 2019, 61 infections were selected for validation, with 98% compliance with original documentation. One minor discrepancy was attributed to interpretation of documentation in the medical record. Medical complexity accounted for 78% of reviews and validation time spent averaged 12 minutes per infection (range, 3–28 minutes). Self-reported effort directed from infection preventionists to 2 IPAs for surveillance was ~20 hours per week. An additional IPA was hired to perform surveillance in addition to other job responsibilities. **Conclusions:** Centralized surveillance programs can promote high reliability and cost-efficient IPC staffing for large healthcare systems, especially those with mandatory reporting requirements or medically complex patient populations. Improving surveillance skills among associate staff can increase experienced infection preventionist bandwidth for project management, staff supervision, and other leadership responsibilities. Lastly, validation programs are crucial to ensuring quality assurance of data reporting to both internal and external stakeholders.

Funding: None
Disclosures: None
Doi:10.1017/ice.2020.850

Presentation Type:
Poster Presentation

Implementing a Massive Personal Protective Equipment Education—A Multidisciplinary Team Approach

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Background: Personal protective equipment (PPE) is defined by the Occupational Safety and Health Administration as specialized clothing or equipment worn by an employee for protection against infectious materials. They include gloves, gowns, masks, respirators, googles and face shields. The CDC has issued guidelines on appropriateness of when, what, and how to use PPE. Despite these guidelines, compliance with PPE remains challenging. **Methods:** We implemented a massive hospital-wide rapid education program on PPE donning and doffing of all employees and staff. This program included an online video, return demonstration and just-in-time training. To develop the program, we recorded PPE training video, reviewed PPE validation checklist, developed new isolation precaution signage with quick response (QR) code to video, developed a nutrition tray removal video and a equipment cleaning video, developed family and visitor guidelines for isolation precautions, and created an audit

tool for PPE donning and doffing practices. The program required interdisciplinary collaboration including administration, infection prevention, nursing education, central supply, environmental services, facility maintenance, and security. **Results:** The first phase of the program was implemented through 30 separate 4-hour PPE skills fair offered over 48 hours. In total, 500 staff members were trained in the first 48 hours; 6 additional 3-hour sessions were provided on site in the following 3 month. Additionally, training was provided in off-site clinics, physician leadership meetings, new-hire orientation for nursing staff, and monthly resident and fellow training through graduate medical education. As needed, training was provided by infection prevention, nursing education, and floor nurses. In total, 5,237 staff members were trained within 3 months after implementation. Actual audit results (50 audits per week) showed improved and sustained compliance to >94%. **Conclusions:** A massive hospital-wide educational program including online video, return demonstration, and just-in-time training is a feasible and very effective method to improve compliance with PPE donning and doffing. A multidisciplinary team approach, administration support, and continuous education and audits are key factors in successful implementation.

Funding: None
Disclosures: None
Doi:10.1017/ice.2020.851

Fig. 1.

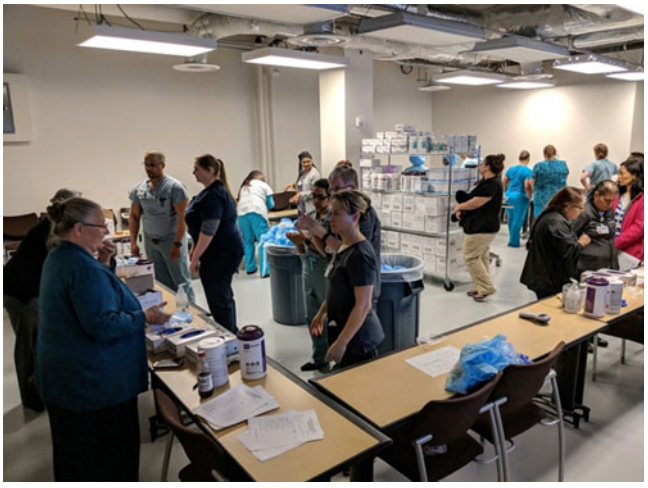

Fig. 2.

Presentation Type:
Poster Presentation

Implementing Admission Screening for Candida auris

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Background: *Candida auris* is a globally emerging, multidrug-resistant fungal pathogen that causes serious, difficult-to-treat infections in hospitalized patients. *C. auris* cases in the United States have been linked to receipt of healthcare overseas. Outbreaks have also occurred in New York City, New Jersey, Chicago, and most recently in California. We provide care to patients from all 50 states and 138 countries; therefore, we are at risk for encountering *C. auris* in our facility. **Setting:** An academic, tertiary-care center with 1,297 licensed beds and >62,000 admissions each year. **Methods:** Infection prevention and control (IPAC) initiated a *C. auris* screening program in August 2019 in partnership with the State Health Department. A case-finding tool was created to identify adult patients admitted in the previous 24 hours from countries and areas of the United States (Chicago, New Jersey, and New York metropolitan areas) with known *C. auris* transmission based on the zip code of their primary address. IPAC sends an electronic communication via the electronic medical record (EMR) alerting the patient care team that the patient meets criteria for screening along with information on *C. auris* and links to a tool kit with additional resources to help answer questions. After obtaining verbal consent, the patient's primary nurse collects a composite axilla–groin skin swab using a nylon-flocked swab (BD ESwab collection and transport system; Becton Dickinson, Sparks, MD). The sample is sent to the State Health Department laboratory for testing by polymerase chain reaction (PCR). Results are communicated back to IPAC and then scanned into the patient's EMR. **Results:** From August 2019 to November 2019, 157 patients were identified for *C. auris* screening using the case-finding tool. Testing was performed on 95 patients; all tests were negative. The primary reasons for testing not to be performed on eligible patients were inability to obtain verbal consent and patient dismissal before sample could be obtained. The need for a special swab that is not routinely stocked on patient care units has been a limitation to timely specimen collection. **Conclusions:** The EMR can be leveraged for early identification and screening of patients at risk of *C. auris* colonization. Case finding tools can be effectively replicated and modified to respond to emerging infections and changing surveillance guidelines.

Funding: None
Disclosures: None
Doi:10.1017/ice.2020.852

Presentation Type:
Poster Presentation

Implementing an Automated Pneumonia Surveillance System

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Background: Although definitions from the CDC were developed to increase the reliability of surveillance data, reduce the burden of surveillance in healthcare facilities, and enhance the utility of surveillance data for improving patient safety, the algorithm is still laborious for manual use. We implemented an automated surveillance system that combines 2 CDC pneumonia surveillance definitions to identify pneumonia infection in inpatients. **Methods:** The program was implemented at an academic health center with