

cefoxitin, or methicillin has declined consistently over the past 10 years. Continued efforts in infection prevention and antimicrobial stewardship are vital to sustaining this decline.

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#### Presentation Type:

Poster Presentation

#### Changing the Culture of Ordering Urine Cultures

Jane Adams, Summa Health; Thomas File, Summa Health System; Matthew England, Summa Health System; Nancy Reynolds, Summa Health System; Patricia Wells, Summa Health System; Paula Politis, Summa Health System

**Background:** Inappropriate ordering of urine cultures and the resulting unnecessary use of antibiotics can lead to complications of antimicrobial therapy including resistance, adverse effects (eg, disruption of microbiome and *C. difficile* infection), and increased healthcare costs, as well as the erroneous determination of CAUTI in patients with Foley catheters. A retrospective analysis of patients with CAUTI revealed frequent ordering of urine cultures for conditions and symptoms not supported by current IDSA guidelines. As a result, we created an action plan to reverse the trend of inappropriate urine culture ordering. **Methods:** Our urine culture reduction campaign was developed with input from the infectious disease service, antibiotic stewardship team (AST), infection prevention, pharmacy, and the microbiology service. The following educational efforts were included: (1) distribution of outpatient pocket cards with communication to providers about appropriate ordering of urine cultures; (2) creation of an evidence-based order set for urinalysis and urine cultures distributed electronically as emails and screensavers on computer stations and in person via didactic sessions with physicians and nursing staff; (3) a practice pointer for staff nurses that included recommended changes to urine culture ordering and encouraged open dialogue with physicians regarding the appropriateness of urine cultures; (4) didactic and personal communications to counter long-standing myths, such as “Urine cultures always for change in mental status”; (5) a peer-review process to evaluate and justify deviations from the testing algorithm.

**Results:** The first and second months after the introduction of the campaign, the microbiology laboratory reported 23% and 37% reductions in urine cultures ordered, respectively. During the same period, a 48% reduction in CAUTIs was reported for the entire health system. **Conclusions:** Reducing the number of inappropriate urine cultures is achievable with intense communication utilizing a multifaceted approach. With continued educational activities, we expect to sustain and even improve our successful reduction of inappropriate urine culture orders, ultimately improving patient outcomes.

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#### Characteristics of *Candida auris* Patients at a Tertiary-Care Hospital, 2017–2019, Nairobi, Kenya

Loice Ombajo, University of Nairobi; Malcolm Correia, The Nairobi Hospital; Alice Kanyua, The Nairobi Hospital; Cheptoo Bore, The Nairobi Hospital; Phoebe Juma, The Nairobi Hospital; Edith Muthui, The Nairobi Hospital; Joan Osoro-

Mbui, The Nairobi Hospital; Elizabeth Bancroft, National Center for Emerging and Zoonotic Infectious Diseases, US Centers for Disease Control and Prevention, Atlanta; Jackson Brendan R, National Center for Emerging and Zoonotic Infectious Diseases, US Centers for Disease Control and Prevention, Atlanta; Mitsuru Toda, National Center for Emerging and Zoonotic Infectious Diseases, US Centers for Disease Control and Prevention, Atlanta

**Background:** *Candida auris* is of global concern due to its increasing frequency in intensive care units (ICUs), reported resistance to antifungal agents, propensity to cause outbreaks, and persistence in clinical environments. We investigated an increase in *C. auris* cases in an ICU in Kenya to determine the source of transmission and to control the spread of the disease. **Methods:** To identify cases, we reviewed laboratory records of patients with blood cultures yielding *C. auris* and organisms for which it is commonly misidentified by Vitek 2 v 8.01 software (ie, *C. haemulonii*, *C. duobushaemulonii* and *C. famata*) during January 2018–May 2019. We retrospectively reviewed medical charts of *C. auris* patients to extract information on demographics, underlying conditions, hospital procedures, treatments, and outcomes. We also enhanced infection control efforts by implementing contact precautions, equipment, and environmental disinfection, and hand hygiene training and compliance observations. **Results:** We identified 32 *C. auris* patients (Fig. 1). Median patient age was 55 years (IQR, 43–65), and 57% were male. Length of hospitalization before *C. auris* isolation was 30 days (IQR, 14–36). All had been admitted to the ICU. The most common reasons for admission were sepsis (50%), pneumonia (34%), surgery (25%), and stroke or other neurologic diagnosis (25%). Underlying comorbidities included hypertension (38%), diabetes mellitus (25%), and malignancy (29%). Two patients had HIV. Moreover, 61% of cultures yielded multidrug-resistant bacteria. Also, 33% of the patients had been admitted to this hospital in the preceding 3 months; 21% had been admitted to a hospital outside of Kenya; and 10% had been admitted to another hospital in Kenya in the previous year. Almost all (97%) had a central venous catheter, 45% had an acute dialysis catheter, 66% had an endotracheal tube, and 34% had a tracheostomy, with 69% receiving mechanical ventilation before *C. auris* isolation. Most (94%) had urinary catheters, 84% had nasogastric tubes, 91% had received total parenteral nutrition, and 75% had received blood products. All patients received broad-spectrum antibiotics and 49% received an antifungal before *C. auris* isolation. All-cause in-hospital mortality was 64% for the 28 patients whose outcomes were available. Following implementation of a hand

Figure 1: Epidemic curve of *Candida auris* cases at a tertiary care hospital during 2017–2019, Nairobi, Kenya

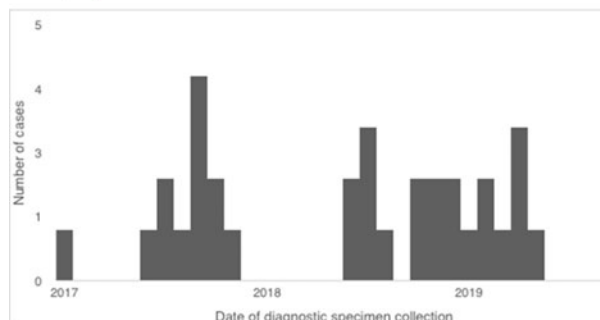


Fig. 1.