

Fig. 1.

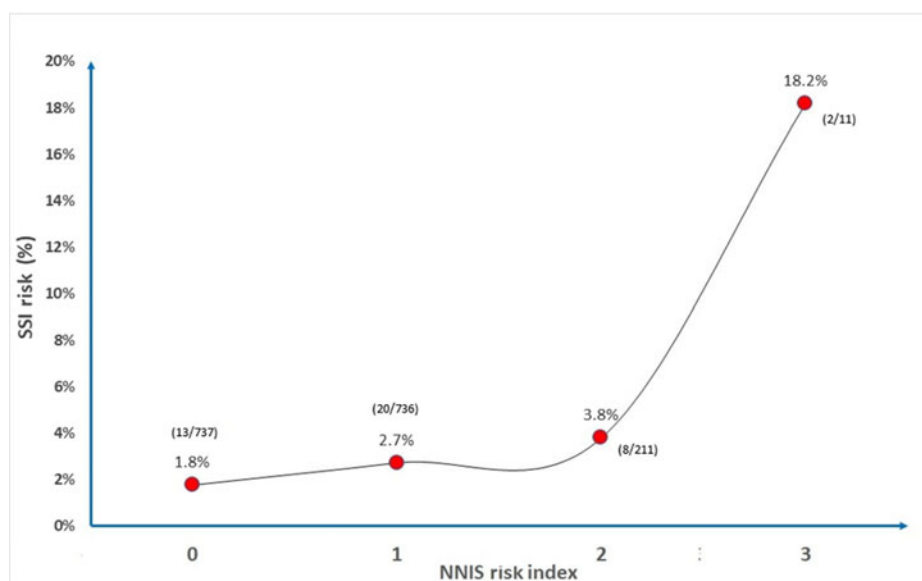


Fig. 2.

1; 8 of 211 SSIs (3.8%) had an NNIS risk index of 2; and 2 of 11 SSIs (18.2%) had an NNIS risk index of 3 (Fig. 2). **Conclusions:** We identified intrinsic risk factors for SSI after orthopedic trauma surgery. The identification of the actual SSI incidence after trauma surgery in developing country hospitals and associated risk factors may support actions to minimize the complications caused by SSI.

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Presentation Type:

Poster Presentation

Risk to Hospitals During a Community Hepatitis A Outbreak: Flipping the Perspective

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Background: In February 2019, in the context of a nationwide community-based hepatitis A (HAV) outbreak, Eskenazi Health (EH), an

acute-care hospital in Indianapolis, Indiana, identified a healthcare worker (HCW) with HAV who had potentially exposed patients via medicine administration. **Objective:** We began an investigation and mitigation plan to determine the source of the HAV and the risk to patients. **Methods:** The investigation and mitigation consisted of 6 measures. (1) We searched the electronic medical record (EMR) tracer report to determine whether any of the HCW's patients had HAV during the incubation period (15–50 days prior to diagnosis) or were potentially exposed during the infectious period (0–14 days prior to diagnosis). 2. We searched the EMR and CHIRP (Indiana's electronic vaccine database) for potentially exposed patients to determine HAV immunity or HAV vaccination (HAVx). (3) We contacted potentially exposed patients. (4) We communicated with public health partners. (5) We investigated other potential exposures. (6) We communicated with employees regarding free HAVx and the community HAV outbreak via e-mail newsletters (reaching almost 6,000 unique addresses) and posts on our internal website. **Results:** The HCW had not provided care for a patient with diagnosed HAV during the incubation period. The HCW had provided care for 14 patients during the infectious period. No potentially exposed patient had evidence of HAV immunity or HAVx in EMR or CHIRP. We initiated communication to all 14 patients or their surrogates regarding the potential exposure, symptoms of HAV, testing, and HAVx. We could confirm HAV testing for only 1 of 14 patients, and the result was negative. None of the 14 patients developed HAV. Public health partners confirmed notification of the HCW case. No further information about the HCW's HAV source was determined. The HCW did not share community food at work. No workplace source of HAV was identified. HAVx dispensed at the pharmacy increased after communication about availability: December 2018–February 2019, 4 HAVx dispensed and March–May 2019, 82 HAVx dispensed. **Conclusions:** Traditionally,

hospitals view infection risk in terms of HCWs acquiring infections from or spreading infections among patients. Viewed this way, the Indiana HAV community outbreak, although serious for the community, did not appear to be a threat to the hospital: HAV acquisition in hospitals has been rare, which is supported by our results. However, this episode demonstrates that the traditional view needs to be flipped: HCWs can bring community-acquired HAV into the hospital. Nudges can quickly increase HAVx uptake among HCWs.

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Role of the Environment in Transmission of Multiresistant *Enterobacter cloacae* in a Hematology-Oncology Department

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Background: The patient environment is increasingly considered a major source of transmission of nosocomial bacteria to patients. In May 2019, a cluster of 3 patients with multiresistant *Enterobacter cloacae* was discovered in the hematology-oncology department of the Maastricht University Medical Center (built in 1991). The strains had an identical antibiogram: ESBL-positive, ciprofloxacin R, cotrimoxazole R, meropenem S, and colistin S. One neutropenic patient had a positive blood culture for this strain,

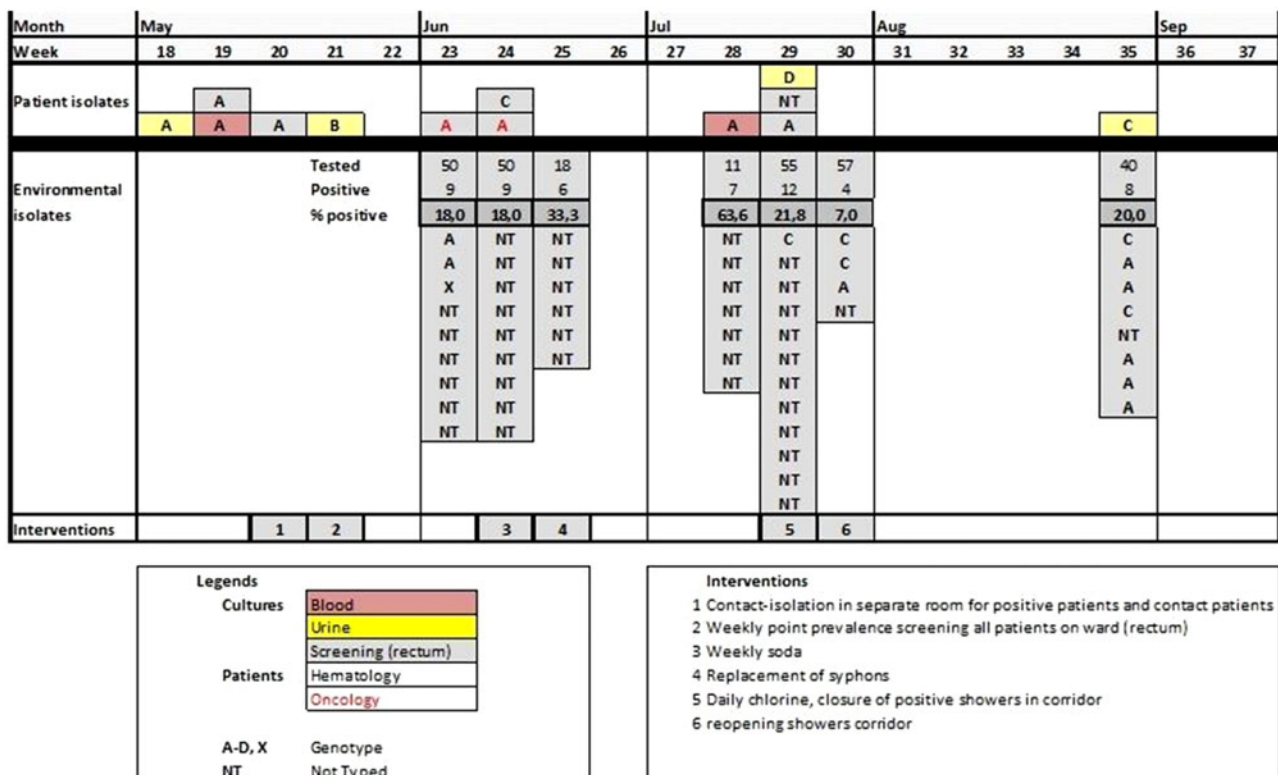


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