Training on Infection Control And Prevention with Healthcare workers (Nurses)

Training on Infection Control And Prevention with Healthcare workers (Doctors)

***Results.*** A total of 1562 HCW's participated in the training: 804 doctors, 445 nurses and 313 support staff in 26 training sessions. Majority of the participants (85%) did not receive any formal training earlier on infection control and often provided incorrect responses on basic IPC during interactive session. None of the hospitals had an IPC committee. After the training, we found a significant increase from 0% at baseline to 24% ($p< 0.001$) in hand hygiene including 43% ($p< 0.001$) and 45% ($p< 0.001$) in mask and gloves use respectively. All respondents (n=84) from the qualitative assessment, reported the training as highly effective which reinforce their learning in action in the hospitals. Participants from all three groups urged to arrange refresher training more frequently and in small groups to uphold the practices.

***Conclusion.*** This pilot program demonstrated HCWs lack basic IPC principals and tailored IPC training sessions can significantly improve HCWs IPC practice. Formation of active IPC committee could enable arranging periodic refresher and in-service training updates for HCWs with the reallocation of resources to adopt regular IPC practices.

***Disclosures.*** **All Authors**: No reported disclosures

### 867. The Scope of a Weekly Infection Control Team Rounding in an Acute-care Teaching Hospital

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**Session:** P-40. HAI: Occupational Infection Prevention

***Background.*** Activities of infection control and prevention are diverse and complicated. Regular and well-organized inspection of infection control is essential element of infection control program. The aim of study was to identify strong points and limitations of weekly infection control rounding (ICTR) in an acute care hospital.

***Methods.*** We conducted weekly ICTR to improve the compliance of infection control in the real field at a 734-bed academic hospital in Republic of Korea. The monitoring team consists of five infection prevention practitioners and four infectious diseases physicians. Total 85 practices of infection control and prevention belonging to the respective category among 9 categories were observed. The result of the rounding are categorized well maintained, improvement is needed, long-term support such as space or manpower is needed, not applicable and could not observed. We investigated retrospectively the functional coverage of a weekly ICTR from January to December 2018.

***Results.*** During the study period, weekly ICTR were performed total 47 times in 37 departments. ICTR visited median 7 times [interquartile range (IQR) 6-7 times] per department. When visiting a department, ICTR observed median 16 practices (IQR 12-22). During the monitoring period, we could observe 7511 practices in total. Of those results, Most of the practices (74.8%) were able to be monitored properly by ICTR, while some of the practices were not applicable (21.3%) or difficult to observe through ICTR (3.9%)(Table 1). The most common practices among the difficult-to-observe group belong to strategies to prevent catheter-related or surgical site infection and pneumonia (13%, 68/538), safety injection practices (8%, 65/758), linen and laundry management (7%, 33/496), followed by strategies to prevent occupationally-acquired infection (6%, 37/578).

Table 1.

**Table 1.** Results of infection control team rounding

| Categories of practices | A (%) | B (%) | C (%) | D (%) | E (%) | Total |
|---|---|---|---|---|---|---|
| Hand hygiene | 936 (93.6) | 46 (4.6) | 0 | 0 | 18 (1.8) | 1000 |
| Safety injection practice | 664 (75.0) | 28 (3.2) | 1 (0.1) | 127 (14.4) | 65 (7.3) | 885 |
| Isolation | 391 (57.5) | 12 (1.8) | 0 (0) | 262 (38.5) | 15 (2.2) | 680 |
| Strategies to prevent occupationally acquired infection | 506 (80.6) | 35 (5.6) | 0 | 0 | 37 (5.9) | 628 |
| Practice to prevent catheter-related (central, urine catheter) or surgical site infections and pneumonia | 451 (48.6) | 19 (2.0) | 0 (0) | 390 (42.0) | 68 (7.3) | 928 |
| Decontamination, disinfection, and sterilization | 1349 (69.6) | 128 (6.6) | 12 (0.6) | 388 (20.0) | 61 (3.1) | 1938 |
| Linen and laundry | 451 (78.7) | 33 (5.8) | 6 (1.0) | 77 (13.4) | 6 (1.0) | 573 |
| Environmental prevention of infection | 403 (68.1) | 24 (4.1) | 0 | 142 (24.0) | 23 (3.9) | 592 |
| Maintain negative/positive pressure | 57 (25.0) | 6 (2.6) | 0 | 165 (72.4) | 0 | 228 |
| Total | 5208 (69.9) | 331 (4.4) | 19 (0.3) | 1601 (21.5) | 293 (3.9) | 7452 |

A: "well maintained", B: "improvement is needed", C: "long-term support such as space or manpower is needed", D: "not applicable" and E: "could not be observed."

***Conclusion.*** ICTR has strength in regular visits to each department. However, additional observation is necessary, especially for prevention of cathether-related infection and surgical site infection.

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### 868. Investigations of Healthcare-Associated *Elizabethkingia* Infections – United States, 2013-2019

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**Session:** P-41. HAI: Outbreaks

***Background.*** *Elizabethkingia* (EK) are non-motile gram-negative rods found in soil and water and are an emerging cause of healthcare-associated infections (HAIs). We describe Centers for Disease Control and Prevention (CDC) consultations for healthcare-associated EK infections and outbreaks.

***Methods.*** CDC maintains records of consultations with state or local health departments related to HAI outbreaks and infection control breaches. We reviewed consultations involving EK species as the primary pathogen of concern January 1, 2013 to December 31, 2019 and summarized data on healthcare settings, infection types, laboratory analysis, and control measures.

***Results.*** We identified 9 consultations among 8 states involving 73 patient infections. Long-term acute-care hospitals (LTACHs) accounted for 4 consultations and 32 (43%) infections, and skilled nursing facilities with ventilated patients (VSNFs) accounted for 2 consultations and 31 (42%) infections. Other settings included an acute care hospital, an assisted living facility, and an outpatient ear, nose, and throat clinic.

Culture sites included the respiratory tract (n=7 consultations), blood (n=4), and sinus tract (n=1), and *E. anophelis* was the most commonly identified species. Six consultations utilized whole genome sequencing (WGS); 4 identified closely related isolates from different patients and 2 also identified closely related environmental and patient isolates.

Mitigation measures included efforts to reduce EK in facility water systems, such as the development of water management plans, consulting water management specialists, flushing water outlets, and monitoring water quality, as well as efforts to minimize patient exposure such as cleaning of shower facilities and equipment, storage of respiratory therapy supplies away from water sources, and use of splash guards on sinks.

***Conclusion.*** EK is an important emerging pathogen that causes HAI outbreaks, particularly among chronically ventilated patients. LTACHs and VSNFs accounted for the majority of EK consultations and patient infections. Robust water management plans and infection control practices to minimize patient exposure to contaminated water in these settings are important measures to reduce infection risk among vulnerable patients.

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### 869. Outbreak of Vancomycin Resistant Enterococcus faecium (VREfm) in a Hematology Unit Identified Through Whole Genome Sequencing

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