Results. Figure 1 shows the number of UCs recommended for removal by RNs vs. CQIS (bars), as well as the percent discordance between RNs and CQIS (line). CQIS identified many more removable UCs than the RNs (888 vs. 256). 211 UC were removed after RN recommendations, and an additional 386 UCs were removed as a result of the CQIS audits. Figure 2 shows the marked corresponding decline in our SUR over this intervention.

Conclusion. As more units participated in the initiative, we saw increasing numbers of "discontinue UC" recommendations. Over time there was also a moderate decrease in the discordance between RN and CQIS recommendations for UC removal. CQIS routinely identified many more UCs to be removed compared with RNs, and more than doubled the number of discontinued UC. Notably, the UC SUR markedly improved, decreasing from 0.98 to 0.78.

Figure 1

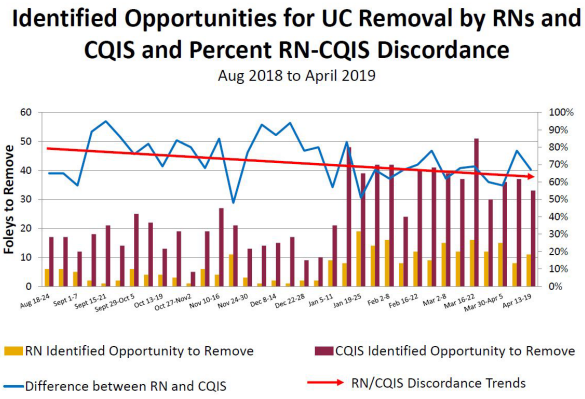
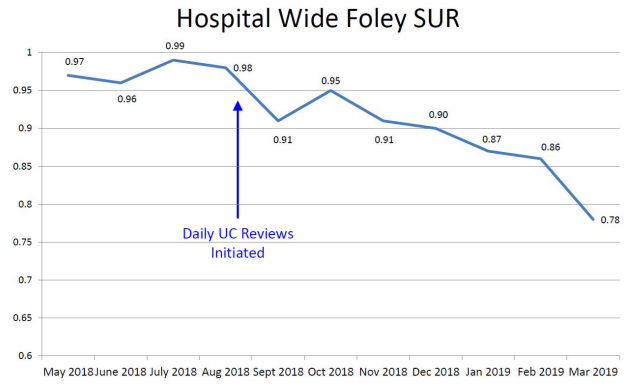


Figure 2



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

1158. Discontinuation of Urine Cultures by Infection Preventionists in Hospitalized Patients with Indwelling Urinary Catheters: Is It Safe?

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Session: 141. HAI, Device-Associated: CAUTI

Friday, October 4, 2019: 12:15 PM

Background. A majority of healthcare-associated urinary tract infections (UTIs) are caused by the use of urinary catheters (CAUTI). Finding of bacteriuria is common in catheterized patients and often leads to unnecessary antibiotic treatment, increased length of stay and additional healthcare costs. We implemented an innovative intervention to improve urine culture (UCx) orders and prevent overdiagnosis of CAUTIs.

Methods. Orders for UCx in adult patients with short-term urinary catheters at NorthShore University HealthSystem, IL were reviewed daily for appropriateness based on the Infectious Diseases Society of America Guidelines. Appropriate urine testing was defined as: (1) presence of fever (>38°C) within past 48 hours, (2) new urinary complaints: flank or suprapubic pain/tenderness or dysuria, frequency, urgency or incontinence within 48 hours after catheter removal, and (3) no other reasonable explanation for fever. If UCx was deemed inappropriate, ordering provider was contacted to cancel the order. Chart review was performed at least 30-days post-discharge to determine whether patients developed recurrent UTI, sepsis, were readmitted or expired.

Results. Between 1 January to 31 March 2019, 65 UCx were submitted. Sixty-four patients (98%) did not meet criteria for testing. Most common reasons for not meeting criteria were absence of fever (60%) and no localizing UTI signs or symptoms (57%). 35 (54%) UCx were canceled after discussion with ordering providers. 21/35 patients (60%) were treated with antibiotics. All 35 patients were discharged, with a majority going to a skilled nursing facility (34%) or home (31%). 4/35 (11%) had a subsequent positive UCx. Two patients developed symptomatic UTI (sUTI) during the index admission. Two patients developed sUTI within 30-days post-discharge; one patient was transitioned to hospice after completion of therapy. All 4 patients were treated for sUTI.

Conclusion. We were able to safely discontinue UCx in 89% of patients. A majority of patients were already started on empiric treatment and development of subsequent sUTI was infrequent (11% of patients). Our findings suggest that discontinuation of inappropriately ordered UCx is safe with low risk for sepsis or mortality.

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

1159. Multidisciplinary Leadership Rounds Are Associated with Decreased Urinary Catheter and Central Venous Catheter Device Utilization at a Tertiary Care, Academic Hospital

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Session: 141. HAI, Device-Associated: CAUTI

Friday, October 4, 2019: 12:15 PM

Background. Optimizing use of urinary catheters (UCs) and central venous catheters (CVCs) is crucial to prevent catheter-associated urinary tract infections (CAUTIs), central line-associated bloodstream infections (CLABSIs), and other complications. Despite education and adoption of catheter removal protocols, indwelling devices not meeting approved indications were still noted.

Methods. Twice a week, UC and CVC surveillance rounds were conducted by a team of directors from nursing, vascular access, infection prevention, and hospital epidemiology. Different hospital units were selected each week in random distribution. Rounds emphasized face-to-face discussion with nurses and device observations to identify any removal opportunities and appropriate maintenance. Device utilization was monitored using CDC National Healthcare Safety Network (NHSN) standardized utilization ratio (SUR) and CAUTIs and CLABSIs were monitored using NHSN definitions. Relative ratios of SURs during pre-intervention (pre-INT) and post-intervention (post-INT) time periods for UCs and CVCs were compared using an exact binomial test and mid-P 95% confidence interval (CI). CAUTI and CLABSI rates were compared using Fisher's exact test using mid-*P* value.

Results. A baseline time period A of 12 months pre-INT (June 2017-May 2018) was used to compare with the 10-month post-INT time period B (June 2018-March 2019). The UC SURs for periods A and B were 0.813 and 0.696 (Figure 1). The relative ratio shows a post-INT UC SUR that was 85.6% of the pre-INT period (95% CI: 84.1%, 87.2%, $P < 0.001$). CAUTI rates for periods A and B were not statistically significantly different at 2.276 vs. 2.164/1000 catheter days ($P = 0.803$). The CVC SURs for periods A and B were 1.244 and 1.081 (Figure 2). The relative ratio shows a post-INT CVC SUR that was 86.9% of the pre-INT period (95% CI: 85.7%, 88.0%, $P < 0.001$). CLABSI rates for periods A and B were statistically significantly different at 1.27 vs. 0.804/1000 central line days ($P = 0.0335$).

Conclusion. Leadership rounds were associated with a significant decrease in utilization of UCs and CVCs. A significant decrease was noted in CLABSI rates but not in CAUTI rates. Multidisciplinary oversight improved adherence to existing policies and should be considered for optimizing device utilization.

Figure 1: Urinary Catheter SUR

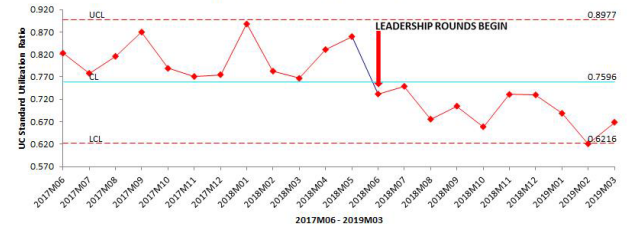
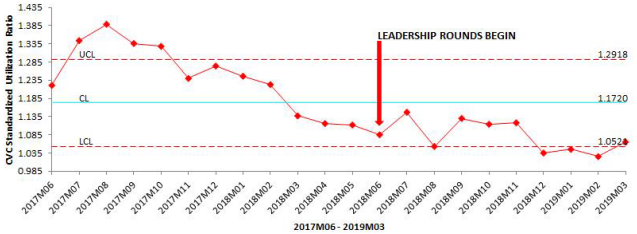


Figure 2: Central Venous Catheter SUR



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