**Conclusions:** The prevalence of HAI in Korea is lower than in most Western countries. The HAI burden of *Clostridium difficile* infection is surprisingly high, which calls for prompt control at the national level. To obtain national-level data on HAI burdens, ongoing surveillance is needed.

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**Presentation Type:**

**Poster Presentation**

**Pilot Testing a Bedside Patient Safety Display to Increase Provider Awareness of the 'Hidden Hazards' of Catheters and Wounds**

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**Figure 1. Patient Safety Display**

**Figure 2. Results for Catheter and Pressure Injury Awareness**

![Image of a patient safety display showing Indwelling Catheters and Skin Alerts with data on PIV, CVC, PICC, and Foley with awareness percentages and injury statistics before and after an intervention.](https://doi.org/10.1017/ice.2020.968)

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Background: Urinary catheters, vascular catheters, and wounds, such as pressure injuries are often hidden from view under gowns and sheets (ie, out of sight, out of mind), contributing to prolonged catheter use, infections, delayed interventions, and diagnostic errors for symptoms (eg, fever or delirium) related to catheters and wounds. We developed and pilot tested a digital bedside “Patient Safety Display” of catheter and wound information to improve awareness by rounding providers (ie, physicians and advanced practice providers, APPs). Methods: The display development was informed by clinical observations of provider rounds and nurse handoffs, interviews, and iterative prototype testing with clinicians in simulated cases using catheterized mannequins with wounds. The display reports the presence and duration of urinary and vascular catheter use, urinary catheter indication, and wound presence and severity, from real-time mandatory nurse documentation in the electronic medical record (Fig. 1). We conducted a pilot study in a tertiary-care medical-surgical-step-down unit with 20 private rooms, including a preintervention period and a post-intervention period including 10 rooms without the display (control rooms) and 10 rooms with the display (intervention rooms). We surveyed individual providers directly after rounds to assess their awareness of their patients’ catheters and wounds compared to medical record documentation. We also assessed display utility and usability from postintervention clinician interviews and we identified major themes using an adapted grounded theory approach. Results: In total, 787 surveys were completed: 681 medicine service with 89% response rate, 106 surgery service with 47% response rate; 363 preintervention surveys, and 424 postintervention surveys. The surveys involved 176 unique patients and 47 unique providers. Among all 787 patient encounters, 156 (19.8%) had a transurethral indwelling urinary catheter (Foley), 314 (39.9%) had a central venous catheter (including PICCs), and 247 (31.4%) had at least 1 pressure injury. Figure 2 summarizes provider awareness of catheters and pressure injuries when present as assessed for patients in the preintervention and postintervention periods. Moreover, 13 clinician postintervention interviews yielded preliminary themes regarding the display’s benefits and limitations (Fig. 3). Conclusions: In this pilot study of a novel Patient Safety Display, although provider awareness of Foley catheters, CVCs, and pressure injuries appeared higher for patients in the intervention rooms compared to awareness as measured in the

preintervention rooms and or postintervention control rooms, most of these comparisons did not meet statistical significance. Clinicians varied widely in their personal assessments of the display as a useful tool for improving awareness and prompting discussion about catheters and wounds.

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Disclosures: Dr. Meddings has reported receiving honoraria for lectures and teaching related to prevention and value-based purchasing policies involving catheter-associated urinary tract infection. The remaining authors report no conflicts of interest.

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Presentation Type: Poster Presentation

Piloting a Quality Improvement Intervention for Urinary Catheter Removal to Reduce Catheter-Associated Urinary Tract Infection in a Medical Intensive Care Unit

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Background: Catheter-associated urinary tract infections (CAUTIs) are among the most prevalent healthcare-associated infections (HAIs) globally, contributing to increased morbidity, prolonged hospital stays, and increased healthcare costs. Interventions that support prompt removal of the urinary catheter are evidence-based actions to effectively reduce CAUTI rates.1

Objective: At the National Hospital of Tropical Disease (NHTD), catheter removal interventions in the intensive care unit (ICU) were implemented using quality improvement (QI) methodology to reduce CAUTI incidence and urinary catheter device utilization. Methods: Training was performed for ICU clinical staff with knowledge checks before and after the program. A bedside visual reminder of CAUTI risk and checklist to assess catheter need were implemented. Weekly compliance of provided visual reminders and checklists were measured using a simple audit tool. Device utilization ratios (DURs, ratios of device days to patient days), and CAUTI incidence rates (per 1,000 device days) were collected at baseline (July–September 2018) and quarterly thereafter until June 2019. Statistical significance was determined by an independent t test. Results: In the first quarter (October–December 2018), the CAUTI incidence rate decreased from 8.9 to 1.3 per 1,000 device days (P = .036). The ICU staff trained in CAUTI prevention, mean knowledge scores before and after training increased from 68% to 87%. The DUR decreased slightly from 0.59 to 0.55 after the first-quarter training then steadily increased in the following quarter (0.60; January–March 2019) and after the intervention (0.54; April–June 2019). CAUTI incidence rates also increased but were still lower than at baseline: 4.8 and 6.3 per 1,000 days of device use. Compliance of reminders was 51% during the first quarter, increased slightly in the second quarter 62%, then