Surgical site infections (SSIs) are a major healthcare issue; they lead to increased morbidity and mortality rates. They also prolong the length of stay and increase the cost to the patient and the healthcare system. Depending on the procedure, the risk of death is 2 to 11 times greater for patients with an SSI than for patients without an SSI. Additionally, the financial burden and patient burden is considerable; it ranks as the most common and costly of hospital-acquired infections (HAIs) and can extend a patient’s length of stay by 11.2 days. The risk of developing an SSI is affected by multiple factors at the patient, operative, and institutional levels.

Methods: A Midwestern healthcare system conducted a review of the recommended best-practice guidelines that are currently accepted as the standards of care in US healthcare facilities. A gap analysis instrument for colorectal SSI prevention was drafted and reviewed for content validity and accuracy by field experts. Hospital infection preventionists worked in conjunction with operating room leaders to disseminate the survey to staff. Responses were collected from June 5 to June 30, 2019. Concurrently, the system infection preventionist team developed a standardized SSI dashboard template that could be used at the hospital, regional, and system level to visualize SSI infection counts, standardized infection ratios (SIRs) as well as procedure count data. These dashboard reports are updated and distributed on a monthly basis to each hospital’s campus executive team and other leaders.

Federal- and state-required procedures were included and additional procedures were included based on hospital risk.

Results: In total, 35 responses were recorded from 8 ministries across the system. Infection preventionists, operating room directors, physicians, nurses, and surgical technologists were represented among the respondents. The following areas were identified areas for improvement: use of chlorhexidine gluconate (CHG) bathing kit, mechanical bowel preparation with preoperative oral antibiotics, hair removal practices, use of fascial wound protector, maintenance of patients’ blood glucose levels, glove and gown changing procedures, and use of antimicrobial-coated sutures. The development and distribution of the SSI dashboard increased awareness and knowledge of SSIs by hospital and system-level leaders.

Conclusions: The implementation of both the gap analysis and dashboard reports improved awareness areas needed for improvement and knowledge of the burden of SSIs. These findings will drive discussions within the hospitals and at the system-level to implement evidence-based practice to improve care and decrease infections as well as guide the development of SSI patient care bundles.

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Implementation Strategies of a Quality Improvement Initiative for Hospital-Acquired *Clostridioides difficile* Infection Prevention

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Background: *Clostridioides difficile* infection (CDI) is the most common cause of infectious diarrhea in hospitalized patients. Probiotics have been studied as a measure to prevent CDI. Timely probiotic administration to at-risk patients receiving systemic antimicrobials presents significant challenges. We sought to determine optimal implementation methods to administer probiotics to all adult inpatients aged ≥55 years receiving a course of systemic antimicrobials across an entire health region.

Methods: Using a randomized stepped-wedge design across 4 acute-care hospitals (n = 2,490 beds), the probiotic Bio-K+ was prescribed daily to patients receiving systemic antimicrobials and was
Implementing a Centralized Surveillance and Validation Program for Infection Prevention

Background: Mandatory reporting of all healthcare-associated infections (HAIs) leads to substantial surveillance volume for infection prevention and control (IPC) programs. Prior to 2019, 6 infection preventionists were performing system-wide surveillance for all infection types using NHSN definitions at a large quaternary-care center in Pennsylvania. Limited surveillance validation was performed. With the continued expansion of the health system, increased demands for IPC expertise, and a growing team, the need for streamlined surveillance, continued expansion of the health system, increased demands for IPC preventionists and practice case studies. Following training, IPAs performed surveillance for experienced infection preventionists covering high-risk inpatient units. To ensure high reliability, surveillance validation was initiated. Each month, ~10% of investigated infections were randomly pulled from the electronic surveillance system and divided among experienced infection preventionists. These validators performed unbiased reviews of the charts based on limited data, including patient demographics and culture results. Validation documentation included noting whether an infection was reportable to NHSN and a rationale. Data on whether or not each patient had a complex medical history and time spent validating each case were collected. Compliance of validator documentation aligning with original documentation was tracked. Discrepancies were discussed as a team and were adjudicated as needed. IPAs tracked hours spent on surveillance to capture effort transitioned from infection preventionists. Results: Between March and July 2019, an average of 223 (range, 178–261) potential infections were reviewed per month. From March through June 2019, 61 infections were selected for validation, with 98% compliance with original documentation. One minor discrepancy was attributed to interpretation of documentation in the medical record. Medical complexity accounted for 78% of reviews and validation time spent averaged 12 minutes per infection (range, 3–28 minutes). Self-reported effort directed from infection preventionists to 2 IPAs for surveillance was ~20 hours per week. An additional IPA was hired to perform surveillance in addition to other job responsibilities. Conclusions: Centralized surveillance programs can promote high reliability and cost-efficient IPC staffing for large healthcare systems, especially those with mandatory reporting requirements or medically complex patient populations. Improving surveillance skills among associate staff can increase experienced infection preventionist bandwidth for project management, staff supervision, and other leadership responsibilities. Lastly, validation programs are crucial to ensuring quality assurance of data reporting to both internal and external stakeholders.

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Implementing a Massive Personal Protective Equipment Education—A Multidisciplinary Team Approach

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Background: Personal protective equipment (PPE) is defined by the Occupational Safety and Health Administration as specialized clothing or equipment worn by an employee for protection against infectious materials. They include gloves, gowns, masks, respirators, googles and face shields. The CDC has issued guidelines on appropriateness of when, what, and how to use PPE. Despite these guidelines, compliance with PPE remains challenging. Methods: We implemented a massive hospital-wide rapid education program on PPE donning and doffing of all employees and staff. This program included an online video, return demonstration and just-in-time training. To develop the program, we recorded PPE training video, reviewed PPE validation checklist, developed new isolation precaution signage with quick response (QR) code to video, developed a nutrition tray removal video and a equipment cleaning video, developed family and visitor guidelines for isolation precautions, and created an audit