middle-income countries, the incidence of SSIs ranged from 1.2 to 23.6 per 100 surgical procedures. This contrasted with rates between 1.2% and 5.2% in high-income countries. **Objectives:** We aimed to leverage the existing surveillance capacities at our tertiary-care hospital to estimate the incidence of SSIs in a cohort of trauma patients and to develop and validate an indigenously developed, electronic SSI surveillance system. **Methods:** A prospective cohort study was conducted at a 248-bed apex trauma center for 18 months. This project was a part of an ongoing multicenter study. The demographic details were recorded, and all the patients who underwent surgery (n = 770) were followed up until 90 days after discharge. The associations of occurrence of SSI and various clinico-microbiological variables were studied. **Results:** In total, 32 (4.2%) patients developed SSI. *S. aureus* (28.6%) were the predominant pathogen causing SSI, followed by *E. coli* (14.3%) and *K. pneumoniae* (14.3%). Among the patients who had SSI, higher SSI rates were associated in patients who were referred from other facilities ($P = .03$), had wound class-CC ($P < .001$), were on HBOT ($P = .001$), were not administered surgical antibiotics ($P = .04$), were not given antimicrobial coated sutures ($P = .03$) or advanced dressings ($P = .02$), had a resurgery ($P < .001$), had a higher duration of stay in hospital from admission to discharge ($P = .002$), as well as from procedure to discharge ($P = .002$). SSI was cured in only 16 patients (50%) by 90 days. SSI data collection, validation, and analyses are essential in developing countries like India. Thus, it is very crucial to implement a surveillance system and a system for reporting SSI rates to surgeons and conduct a robust post-discharge surveillance using trained and committed personnel to generate, apply, and report accurate SSI data.

Presentation Type:
Poster Presentation
Surveillance and Control Efforts for Carbapenemase-Producing Gram-Negatives at a High Burden Vietnam University Hospital

Tuan Huynh, University Medical Center - Ho Chi Minh City, University of Medicine and Pharmacy at Ho Chi Minh City; Vasquez Amber, US Centers for Disease Control and Prevention; Lan Pham, University Medical Center - Ho Chi Minh City; Loan Luong, University of Medicine and Pharmacy at Ho Chi Minh City; Tuan Le, University Medical Center - Ho Chi Minh City; Khanh Le, University Medical Center - Ho Chi Minh City; Duyen Bui, University Medical Center - Ho Chi Minh City; Truc Ta, University Medical Center - Ho Chi Minh City; Dao Nguyen, University Medical Center - Ho Chi Minh City; Thoa Trinh, University Medical Center - Ho Chi Minh City; Yen Nguyen, University Medical Center - Ho Chi Minh City; Diep Bui, University of Medicine and Pharmacy at Ho Chi Minh City; Nga Vo, University of Medicine and Pharmacy at Ho Chi Minh City; Lan Nguyen Thi Phong, US Centers for Disease Control and Prevention; Nga Nguyen, PATH; Bao Nguyen, University of Medicine and Pharmacy at Ho Chi Minh City; Binh Truong, University Medical Center - Ho Chi Minh City

Background: Carbapenem-resistant gram-negative bacteria are an urgent threat to healthcare safety around the world. In Vietnam, Although surveillance and control of multidrug-resistant organisms is a national priority, information on the burden of these resistant pathogens is still scarce. At University Medical Center Ho Chi Minh City, Vietnam, we aimed to better understand carbapenem-resistance through 2 phases: (1) assess proportion of carbapenem-resistant gram-negative organisms that are carbapanemase-producing (CP-CRO) and (2) assess transmission burden of carbapenemase-producing carbapenem-resistant Enterobacterieacea (CP-CRE) in the general intensive care unit (ICU). **Methods:** In the first phase, all gram-negative clinical isolates collected between November 2018 and April 2019 were tested for carbapenem-resistance using the disc-diffusion method and were defined as meropenem resistant using the Clinical and Laboratory Standards Institute 2018 break point (*M100-Performance Standards for Antimicrobial Susceptibility Testing, 28th Edition*). Carbapenem-resistant bacteria were tested for phenotypic carbapenemase-production using the Becton Dickinson Phoenix CPO Detect assay. In the second phase, we instituted CP-CRE rectal screening using CHROMagar mSuperCARBA media for all ICU patients from July through September 2019. Patients were screened on admission, and negative patients were rescreened every 2 days until discharge, death, or CRE-positive screening or culture. Admission prevalence and incidence of CP-CRE transmission was calculated among CP-CRE infected or colonized patients. **Results:** From November 2018 through April 2019, 599 gram-negative clinical isolates from 543 patient samples were identified. Of these, 108 were carbapenem-resistant; 107 (99%) of carbapenem-resistant isolates were carbapenemase-producing by phenotypic method. Most CP-CRO were *Acinetobacter baumannii* (45 of 107, 42%) or *Klebsiella pneumoniae* (39 of 107, 36%). During ICU CP-CRE colonization screening, the July positivity rate on admission was 40% (32 of 81), the August positivity rate on admission was 30% (21 of 71), and the September positivity rate on admission was 40% (30 of 75). Of those with negative admission screen, the proportion of new CP-CRE colonization in July was 45% (22 of 49), the proportion of new CP-CRE colonization in August was 64% (32 of 50), and the proportion of new CP-CRE colonization in September was 44% (20 of 45). Across all 3 months of screening, the proportions of CP-CRE that were *Klebsiella*, *Citrobacter*, or *Enterobacter* were 68% (118 of 174) and the proportion of CP-CRE that were *Eschericia coli* was 37% (56 of 174). The average number of days to turn from negative to positive screening result was 4.1. **Conclusions:** Our analysis demonstrates that nearly all carbapenem-resistant organisms at our hospital are carbapenemase producing. In the ICU, we identified a high burden of CP-CRE, attributable to high presence on admission and new acquisition in the ICU. An intervention package based on CDC-recommended enhanced infection control measures is being implemented to decrease CP-CRE transmission in the ICU.

Presentation Type:
Poster Presentation
Surveillance of Healthcare-Associated Bloodstream and Urinary Tract Infections in a National Level Network of Indian Hospitals

Purva Mathur, All India Institute of Medical Sciences, New Delhi; Paul Malpiedi, US Centers for Disease Control and Prevention; Kamini Walia, Indian Council of Medical Research, New Delhi; Rajesh Malhotra, All India Institute of Medical Sciences, New Delhi; Padmini Srikantiah, Former CDC/BMGF; Omika Katoch, All India Institute of Medical Sciences, New Delhi; Sonal Katyal, All India Institute of Medical Sciences, New Delhi; Surbhi Khurana, All India Institute of Medical Sciences, New Delhi; Mahesh Chandra Misra, MGMC Jaipur; Sunil Gupta, Safdarjang Hospital, New Delhi; Subodh Kumar, All India Institute of Medical Sciences, New Delhi; Sushma Sagar, All India Institute of

Medical Sciences, New Delhi; Naveet Vig, All India Institiute of Medical Sciences, New Delhi; Pramod Garg, All India Institute of Medical Sciences, New Delhi; Arti Kapil, All India Institute of Medical Sciences, New Delhi; Manoj Sahu, All India Institute of Medical Sciences, New Delhi; Arunaloke Chakrabarti, PGI Chandigarh; Pallab Ray, PGI Chandigarh; Manisha Biswal, PGI Chandigarh; Neelam Taneja, PGI Chandigarh; Priscilla Rupali, Christian Medical College; Vellore Binila Chacko, CMC Vellore; Joy Sarojini Michael, CMC Vellore; Veeraraghavan Balaji, CMC Vellore; Camilla Rodrigues, Hinduja Hospital, Mumbai; Vijaya Lakshmi Nag, AIIMS Jodhpur; Vibhor Tak, AIIMS, Jodhpur; Vimala Venkatesh, KGMU Lucknow; Chiranjay Mukhopadhyay, KMC Manipal; KE Vandana, KMC Manipal; Muralidhar Varma, Kasturba Medical College, Manipal University; Vijayshri Deotale, MGIMS Sevagram; Ruchita Attal, MGIMS Sevagram; Kanne Padmaja, NIMS Hyderabad; Chand Wattal, Sir Ganga Ram Hospital, Delhi; Neeraj Goel, Sir Ganga Ram Hospital, Delhi; Sanjay Bhattacharya, Tata Medical Center; Tadepalli Karuna, AIIMS Bhopal; Saurabh Saigal, AIIMS Bhopal; Bijayini Behera, AIIMS Bhubaneswar; Sanjeev Singh, Amrita Institute of Medical Sciences; MA Thirunarayan, Apollo Hospital, Chennai; Reema Nath, Assam Medical College; Raja Ray, IPGMER Kolkata; Sujata Baveja, LTMMC Mumbai; Desma D'Souza, LTMMC Mumbai; Mammen Chandy, Tata Medical Centre, Kolkata; Sudipta Mukherjee, Tata Medical Centre, Kolkata; Manas Roy, Tata Medical Centre, Kolkata; Gaurav Goel, Tata Medical Centre, Kolkata; Swagata Tripathy, AIIMS Bhubaneswar; Satyajeet Misra, AIIMS Bhubaneswar; Anupam Dey, AIIMS Bhubaneswar; Tushar Mishra, AIIMS Bhubaneswar; Hirak Raj, IPGMER Kolkata; Bashir Fomda, SKIMS Kashmir; Gulnaz Bashir, SKIMS Kashmir; Shaista Nazir, SKIMS Kashmir; Sulochana Devi, RIMS Imphal; Khuraijam Ranjana Devi, RIMS Imphal; Langpoklakpam Chaoba Singh, RIMS Imphal; Padma Das, All India Institute of Medical Sciences, Raipur; Anudita Bhargava, AIIMS Raipur; Ujjwala Gaikwad, AIIMS Raipur; Neeta Khandelwal, GMC Surat; Geeta Vaghela, GMC Surat; Tanvi Sukharamwala, GMC Surat; Prachi Verma, MGMC Jaipur; Mamta Lamba, MGMC Jaipur; Shristi Jain, MGMC Jaipur; Prithwis Bhattacharyya, NEIGRIHMS Shillong; Anil Phukan, Neigrihms Shillong; Clarissa Lyngdoh, NEIGRIHMS Shillong; Rajeev Sharma, US Centers for Disease Control and Prevention; Rajni Gaind, Safdarjung Hospital and VMMC, Delhi; Rushika Saksena, Vardhman Mahavir Medical College and Safdurjung Hospital; Lata Kapoor, National Centre for Disease Control; Neil Gupta, US Centers for Disease Control and Prevention; Aditya Sharma, US Centers for Disease Control and Prevention; Daniel VanderEnde, US Centers for Disease Control and Prevention; Anoop Velayudhan, US Centers for Disease Control and Prevention; Valan Siromany, Centers for Disease Control & Prevention; Kayla Laserson, Former CDC/BMGF; Randeep Guleria, All India Institute of Medical Sciences, New Delhi

Background: Healthcare-associated infections (HAIs) are a major global threat to patient safety. Systematic surveillance is crucial for understanding HAI rates and antimicrobial resistance trends and to guide infection prevention and control (IPC) activities based on local epidemiology. In India, no standardized national HAI surveillance system was in place before 2017. **Methods:** Public and private hospitals from across 21 states in India were recruited to participate in an HAI surveillance network. Baseline assessments followed by trainings ensured that basic microbiology and IPC implementation capacity existed at all sites. Standardized surveillance protocols for central-line–associated bloodstream infections (CLABSIs) and catheter-associated urinary tract infections (CAUTIs) were modified from the NHSN for the Indian context. IPC nurses were trained to implement surveillance protocols. Data were reported through a locally developed web portal. Standardized external data quality checks were performed to assure data quality. **Results:** Between May 2017 and April 2019, 109 ICUs from 37 hospitals (29 public and 8 private) enrolled in the network, of which 33 were teaching hospitals with >500 beds. The network recorded 679,109 patient days, 212,081 central-line days, and 387,092 urinary catheter days. Overall, 4,301 bloodstream infection (BSI) events and 1,402 urinary tract infection (UTI) events were reported. The network CLABSI rate was 9.4 per 1,000 central-line days and the CAUTI rate was 3.4 per 1,000 catheter days. The central-line utilization ratio was 0.31 and the urinary catheter utilization ratio was 0.57. Moreover, 3,542 (73%) of 4,742 pathogens reported from BSIs and 868 (53%) of 1,644 pathogens reported from UTIs were gram negative. Also, 1,680 (26.3%) of all 6,386 pathogens reported were Enterobacteriaceae. Of 1,486 Enterobacteriaceae with complete antibiotic susceptibility testing data reported, 832 (57%) were carbapenem resistant. Of 951 Enterobacteriaceae subjected to colistin broth microdilution testing, 62 (7%) were colistin resistant. The surveillance platform identified 2 separate hospital-level HAI outbreaks; one caused by colistin-resistant *K. pneumoniae* and another due to *Burkholderia cepacia*. Phased expansion of surveillance to additional hospitals continues. **Conclusions:** HAI surveillance was successfully implemented across a national network of diverse hospitals using modified NHSN protocols. Surveillance data are being used to understand HAI burden and trends at the facility and national levels, to inform public policy, and to direct efforts to implement effective hospital IPC activities. This network approach to HAI surveillance may provide lessons to other countries or contexts with limited surveillance capacity.

Presentation Type:
Poster Presentation

Surveillance of ICU Patients for *Candida auris* in a Suburban Chicago Hospital System: Results of a Limited Trial

Mary Alice Lavin, Lavin Consulting, LLC; Donna Schora, North Shore University Health System; Adrienne Fisher, North Shore University Health System; Bridget Kufner, North Shore University Health System; Rachel Lim, North Shore University Health System Evanston Hospital; Cherie Faith Monsalud, NorthShore University Health System; Mona Shah, NorthShore University Health System; Shane Zelencik, NorthShore University Health System; Kamaljit Singh, Evanston Hospital/ NorthShore University Health System

Background: *Candida auris* prevalence in Illinois, particularly in the metropolitan Chicago area, is high. The Illinois Department of Public Health recommends empiric contact precautions for patients with a tracheostomy or requiring mechanical ventilation from skilled nursing facilities (vSNFs) or long-term acute-care hospitals (LTACHs) who are admitted to an acute-care hospital. Cases of *C. auris* infection and colonization are reportable to the Illinois Extensively Drug Resistant Organism Registry (XDRO Registry). NorthShore University HealthSystem (NSUHS) actively screens adult intensive care unit (ICU) admissions from LTACHs and vSNFs for CA. **Methods:** NSUHS is a 4-hospital system located north of Chicago with 750 beds, 4 ICUs and ~64,000 annual admissions. Beginning in April 2019, a composite axilla–groin swab was collected from