

at HHC agencies. In this study, we investigated barriers and facilitators of effective IPC in HHC. **Methods:** In 2018, we conducted in-depth, telephone interviews with 41 staff from 13 agencies across the United States including administrators, IPC and quality improvement personnel, registered nurses and HHC aides. Interview transcripts were coded in NVivo v 12 software (QSR International), and themes were identified using content analysis. **Results:** We identified 4 themes: (1) IPC as a priority, (2) uniqueness of home health care, (3) importance of education, and (4) keys to success and innovation. When discussing the top priorities in the agency, participants described IPC as a big part of patient safety and as playing a major role in reducing rates of rehospitalization. Protection of patients and staff was described as a major motivator for compliance with IPC policies and procedures, and agencies placed specific focus on improving hand hygiene, bag technique, and disinfection of equipment. Almost all participants described the uniqueness of providing health care in a patient's home, which was often talked about as an unpredictable environment due to lack of cleanliness, presence of pets and/or pests, and family dynamics. Furthermore, the intermittent nature of HHC was described as affecting effective implementation of IPC procedures. Education was seen as a tool to improve and overcome patient, caregiver, and families' lack of compliance with IPC procedures. However, to be effective educators and role models, participants stated that they themselves needed to be properly educated on IPC policies and procedures. Several keys to success and innovation were discussed including (1) agency reputation as a key driver of quality; (2) agency focus on quality and patient satisfaction; (3) using agency infection data to improve the quality of patient care; (4) utilizing all available resources within and outside of the agency, and (5) a coordinated approach to patient care with direct, multimodal communication among all clinical disciplines. **Conclusions:** This qualitative work identified barriers to effective infection prevention and control in HHC and important facilitators that HHC agencies can use to improve implementation of policies and procedures to improve patient care.

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#### Challenges in Identification of *Candida auris* in Hospital Laboratories: Comparison Between HIC and LMIC

Sharmila Sengupta, National Center for Infectious Diseases, Singapore; Kalisvar Marimuthu, Tan Tock Seng Hospital; Andrew Stewardson, Monash University; Stephan Harbarth, Geneva University Hospitals; Amanda Durante, University of Connecticut School of Medicine; Sanjeev Singh, Amrita Institute of Medical Sciences

**Background:** *Candida auris* is an emerging nosocomial fungal pathogen causing invasive illness and outbreaks worldwide. A major issue regarding *C. auris* is that it can be misidentified unless appropriate technology is used. We conducted a survey of available methods for identification of *C. auris* in 21 hospital laboratories in India regarding their protocols for prevention of *C. auris* infection. **Methods:** The survey was an adaptation of a similar survey conducted for the Connecticut Laboratory Response Network in 2017. We mailed the survey to 30 microbiologists and ID physicians, and 21 of them from 12 states responded. All respondents were from private acute-care and teaching hospitals. The responses were

**Table 1.** Comparison of Results of US and India Study

<i>Candida auris</i> Identification	Acute-Care Hospitals in Connecticut (N = 21), No. (%)	Acute-Care Hospitals in India (N = 21), No. (%)
In-house	17 (81)	19 (90.5)
Automated systems	21 (100)	19 (90.5)
Speciation from sterile sites like blood	16 (76.2)	18 (85.7)
Speciation from other sites - Respiratory - Urinary	9 (42.9) 11 (52.4)	9 (42.9) 13 (61.9)
MALDI-TOF	5 (23.8)	1 (4.8)
PCR	0	1 (4.8)
Antifungal susceptibility testing	2 (9.5)	19 (90.5)

analyzed and compared to the Connecticut study. **Results:** Of 21 hospitals, 19 (90.5%) can identify *C. auris* in house. Also, 18 (85.7%) have identified *C. auris* in the past 18 months. Species level identification was done only for blood cultures in all hospitals. Only 5 (26%) laboratories speciated *Candida* spp isolated from other sites such as respiratory and urinary specimens. Automated systems were used like Vitek 2 in 16 (84.2%), Phoenix BD in 2(10.5%) and Microscan in 1(5.26%) laboratory. MALDI-TOF MS and PCR for identification were used in 2 laboratories. Antifungal susceptibility testing is done in-house in 19 (90.5%) laboratories. Only 10 (52.6%) responding hospitals from India had infection prevention protocols for *C. auris*, and 9 (47.4%) of them isolated patients. The major challenges for infection prevention with *C. auris* are absence of screening in high-risk patients (66.7%), misidentification by automated systems (84.2%), and inability to speciate from nonsterile sites underestimates the prevalence (100%). **Conclusions:** There is an urgent need to enhance the capacity of hospital laboratories to detect *C. auris* early, and to implement infection prevention measures. In both studies early detection is the key and as suggested by the US authors, challenges can be overcome through collaboration between hospitals and referral laboratories when resources are limited. This optimizes laboratory capacity and prevents global spread through colonized patients. The limitation of this study is that data from public hospitals are unknown and larger studies are needed.

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#### Changes in Regional Hospital-Identified *Clostridioides difficile* Infection, 2015–2018

Raymund Dantes, Centers for Disease Control and Prevention, Emory University; Jonathan Edwards, Centers for Disease Control and Prevention; Qunna Li, Centers for Disease Control and Prevention

**Background:** Regional changes in United States *C. difficile* infection (CDI) are not well understood but important for targeting prevention strategies. **Methods:** Community-onset (CO) CDI was