

MRSA clones in both the ACH and ILTCFs. Hospital stay >14 days and exposure to percutaneous devices were additional risk factors for CC22 colonization in the ACH and ILTCFs, respectively. Pre-emptive contact precautions for prior MRSA-carriers on admission and active screening for long-stayers in the ACH could prevent intra- and interinstitutional MRSA transmission.

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Multidisciplinary Central-Line Bundle Audit Rounding: A Strategy to Reduce CLABSI

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Background: Central venous catheter (CVC) maintenance bundle elements, including labeling IV tubing and dressings, consistently changing them, intact dressings, and dry healthy insertion sites, together have been shown to reduce risks of developing central-line-associated bloodstream infections (CLABSI).^{1,2} CLABSI are a significant, but preventable, cause of mortality among critically ill patients.³ In the last 12 months, the 16-bed medical intensive care unit (MICU) at a large, urban, academic facility had 2,621 central-line days, presenting many opportunities for CLABSI prevention. During that time, weekly observations assessed compliance with CVC maintenance bundle elements. **Interventions:** Multidisciplinary rounds were conducted to monitor nursing staff adherence to CVC maintenance bundle elements. The following bundle elements observed during rounds: (1) Is central-line dressing occlusive/intact? (2) Is CVC insertion site healthy with no redness/drainage? (3) Is CVC dressing labeled with insertion date? (4) Date/time of last dressing change adheres to policy? (4) All CVC tubing is labeled with date/time? (5) All CVC tubing dates adhere to policy? (6) If stopcock is present, is cap present over unused port? “Just-in-time” staff coaching was employed when noncompliance was observed. Findings were sent to leadership for manager follow-up. Staff were informed about products available within the hospital, which can improve dressing adherence and mitigate insertion-site bleeding. Education was provided to staff defining exact requirements for CVC dressings. The acronym “IDOL” was used to help remind staff of these fundamentals: (1) Intact dressing borders are well adhered, with <50% of the white border detached. (2) Drainage should be within the chlorhexidine square. (3) Occlusive means no bubbles, kinks, or wrinkles in the dressing. (4) Labeling is required and must include insertion date, date/time of change, and initials. **Results:** In the first 2 months of rounds, overall compliance averaged 85%. Compliance increased to an average of 91% during the subsequent 10 months. Early on, most fallouts were found with dressings not occlusive or intact and excessive drainage from insertion sites. Initially, 71% of sites were without excess drainage, and 57% of dressings were occlusive or intact. These measures increased to 83% and 89%, respectively, after the interventions. A 50% decrease in the number of CLABSI was observed during the observation period, compared to the previous 12-month period. **Conclusions:** Consistent use

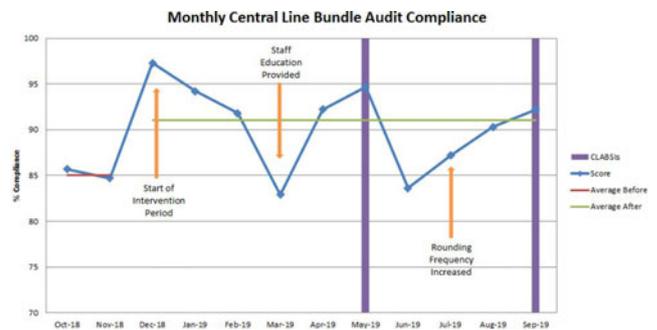


Fig. 1.



Fig. 2.

of bundles has been shown to significantly improve patient outcomes with regard to hospital-acquired infections (HAIs).³ Frequent observations, education to define staff expectations, and holding staff accountable have all helped improve compliance with maintenance bundle elements. Preventing CLABSI is not only important for patient safety and quality of care. Regulatory and accrediting agencies are now increasing their focus on infections and are tying them to reimbursement.

References

1. Honeycutt M, Russell C, Oldridge C. A standardized approach to CLABSI elimination. *Am J Infect Control* 2011;39(5). doi: 10.1016/j.ajic.2011.04.266.
2. Crnich C, Maki D. Intravascular device infection. Association for Professionals in Infection Control website. <http://text.apic.org/toc/prevention-measures-for-healthcare-associatedinfections/intravascular-device-infection>. Published October 3, 2014. Accessed April 5, 2019.
3. Dumont C, Nesselrodt D. Preventing CLABSI: central-line-associated bloodstream infections. *Nursing* 2012;42:41–46.

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Multi-Facility Reduction in Hospital-Acquired Infections (HAIs) Through Real-Time Feedback and Individual Accountability

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