



Fig. 1.

Presentation Type:

Poster Presentation

Clostridioides difficile: Best Practice Alerts & Education to Reduce Unnecessary Testing

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Background: Unnecessary testing for *Clostridioides difficile* can lead facilities to overreport laboratory-identified (LabID) events. Because false-positive LabID tests could dilute infection control resources, we developed best practice alerts (BPAs) in the electronic health record, educational materials as well as a follow-up system to help reduce unnecessary testing and, therefore, reduce false-positive results. **Methods:** Three BPAs were initiated in late August, 2018. Alerts fired when clinicians tried to order repeat *C. difficile* testing after a positive result, testing within 24 hours of laxative administration and to order a multiplex PCR panel for GI pathogens >48 hours after admission. The GI multiplex PCR test consists of 21 targets, including *C. difficile*, but it allows for testing solid stool. All alerts gave suggestions for how to proceed (ie, not test for cure from previous positive, wait until laxatives wear off, or call for approval before GI panel) but could be bypassed by clinicians. Educational emails and signage were distributed to all house staff and clinicians in all clinical areas at the start of the program. For each bypassed BPA, infection control physicians contacted the ordering clinician by email or phone to explain why testing was not advised. **Results:** Between September 5, 2018, and April 23, 2019, 1,217 BPAs were issued: 634 in first half and 583 in the second half. Of these, 268 (22%) were bypassed by clinicians (Fig. 1). There was no significant decrease in bypassing BPAs. In the first half of the intervention, 22% of BPAs were bypassed (141 of 634). In the second 4 months, 22% of BPAs were still bypassed (127 of 583; $P = .85$). Of the 40 ordering services, 8 had no bypassed BPAs in the first half and 9 had no bypassed BPAs in the second half. **Conclusions:** Educating providers and following up after bypassed BPAs did not decrease the number of bypassed BPAs. Although fewer BPAs were issued in the second half of the intervention, more analysis is needed to understand whether this decrease is significant. In this study, 268 unnecessary *C. difficile* tests were ordered over 8 months.

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Clostridium difficile Infection Prevention Bundle Implementation

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Background: The optimal prevention of healthcare onset *Clostridium difficile* infection (CDI) has been a challenging one in an acute tertiary-care hospital with limited number of single rooms. Asymptomatic patients with CDI are nursed in open wards but tagged with a green sticker to alert staff of their status. This signal prompts staff to use 5,000 ppm sodium hypochlorite to clean environmental surfaces in the multibed room and to continue with modified contact precautions. **Methods:** We conducted a survey on infection prevention measures used in the management of CDI patients over 2 weeks among senior nurse managers, clinicians, and registered nurses in 38 inpatient wards. We categorized the survey results into 4 types of practices: established practices, nonestablished practices (easy implementation), nonestablished practices (lack of resources), and nonestablished practices (staff resistance). We then identified barriers to determine reasons for resistance to nonestablished practices before the implementation of the CDI bundle in May 2019. The bundle comprised the following components: contact precautions, antimicrobial stewardship, isolation of CDI patient with diarrhea in single room, environment, and equipment hygiene. Following the survey, we enhanced the signage for CDI patients to be more obvious. Monthly, we monitored the incidence of HO-*Clostridium difficile* to assess effectiveness of implementation measures. **Results:** Nonestablished practices (easy implementation) included uncertainty of diarrhea definition and the recommended environmental hygiene disinfectant, lack of understanding of the importance of complying to personal protective equipment (PPE), and inconsistency in conveying CDI status. Among nonestablished practices (lack of resources), shortage of isolation beds for CDI patients with diarrhea and unavailability of electronic alert system for CDI patients within the institution are the major issues faced by clinical staff. Unavailability of CDI indicator stickers, contact precaution posters, and sporicidal wipes were noted in 6 medical and surgical