

identify exposed persons, validate measles immunity status and risk factors, order prophylaxis, and track outcomes.

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Poster Presentation

**Successfully Sustaining Infection Reductions: A Catheter-Associated Urinary Tract Infection (CAUTI) Prevention Initiative Five Years In**

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**Background:** Infection prevention efforts are complex, and sustaining reductions is even more challenging. At the UNC Medical Center, multidisciplinary hospital-wide work groups implement quality improvement initiatives to prevent healthcare-associated infections. The first and most successful initiative has been our catheter-associated urinary tract infection (CAUTI) prevention effort, which started in 2014. The program led to initial dramatic reductions, with continued reductions in CAUTI rates each year since then.

**Methods:** A multidisciplinary workgroup formed in 2014 developed an evidence-based CAUTI prevention bundle and partnered with the nursing staff in 2015–2016 to implement practice changes as part of our hospital's quality improvement "Spread of Innovations" model. These changes included (1) creation of a 2-person catheter-insertion checklist; (2) insertion skills validation for all nursing staff and nursing assistants; (3) standardization of a maintenance protocol and subsequent education and skills validation with nurses and nurse assistants; and (4) peer audits of urinary catheter maintenance. Additional initiatives implemented over the past 5 years include (1) routine resident education on CAUTI prevention; (2) annual nurse competencies to reinforce skills around CAUTI prevention; (3) introduction of products (eg, PureWick) as alternatives to indwelling catheters; (4) diagnostic stewardship efforts; (5) revisions to the electronic medical record; and (6) efforts to encourage removal of unnecessary catheters such as the "nurse-driven conversation" and

Trial of Void. **Results:** Our CAUTI rates decreased 65% from 2.94 per 1,000 catheter days in the baseline period of 2014 to 1.02 in 2018. In our ICUs (excluding the neonatal ICU), the rate dropped 75% from 4.30 in 2014 to 1.08 per 1,000 catheter days in 2018.

**Conclusions:** We attribute our continued reductions and successful sustainment of low CAUTI rates to several factors. First, the use of a multidisciplinary team was critical to obtaining buy-in from key stakeholders including nursing, nurse assistants, physicians, pharmacists, performance improvement specialists, and administration. Second, continuation of the maintenance peer audits outside the initial project year has provided an important framework for this project, giving regular opportunities for frontline staff to evaluate patients' catheter condition and to give feedback to colleagues or "just in time education." These activities potentially prevent infections in real time. Third, with the many competing priorities demanding clinicians' attention, it has been important for the CAUTI workgroup to continue to evaluate the problem, to determine where opportunities for improvement remain, and to tailor initiatives to meet those needs. In this way, new work can focus on priorities identified by staff, and CAUTI prevention initiatives remain relevant.

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**Supporting Healthcare-Associated Infection (HAI) Surveillance in Resource-Limited Settings: Lessons Learned, 2015–2019**

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**Background:** Since 2015, the CDC has supported the development and implementation of healthcare-associated infection (HAI) surveillance in resource-limited settings through technical support of case definitions and methods that are feasible with existing surveillance capacity and integration with clinical care to maximize sustainability and data use for action. **Methods:** Surveillance initiatives included facility-level implementation programs in Kenya, Sierra Leone, Thailand, and Georgia; larger national or

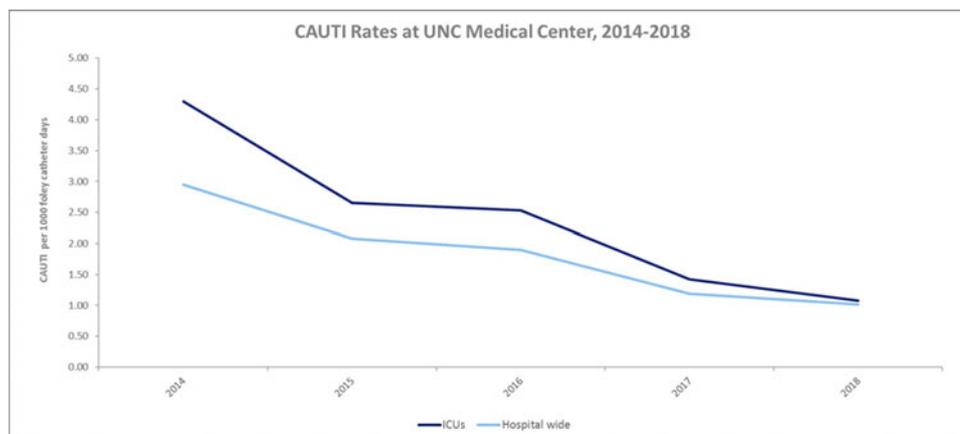


Fig. 1.