tool for PPE donning and doffing practices. The program required interdisciplinary collaboration including administration, infection prevention, nursing education, central supply, environmental services, facility maintenance, and security. **Results:** The first phase of the program was implemented through 30 separate 4-hour PPE skills fair offered over 48 hours. In total, 500 staff members were trained in the first 48 hours; 6 additional 3-hour sessions were provided on site in the following 3 month. Additionally, training was provided in off-site clinics, physician leadership meetings, new-hire orientation for nursing staff, and monthly resident and fellow training through graduate medical education. As needed, training was provided by infection prevention, nursing education, and floor nurses. In total, 5,237 staff members were trained within 3 months after implementation. Actual audit results (50 audits per week) showed improved and sustained compliance to >94%. **Conclusions:** A massive hospital-wide educational program including online video, return demonstration, and just-in-time training is a feasible and very effective method to improve compliance with PPE donning and doffing. A multidisciplinary team approach, administration support, and continuous education and audits are key factors in successful implementation.

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Fig. 1.

Fig. 2.

Presentation Type:
Poster Presentation

Implementing Admission Screening for Candida auris

Jenna Rasmusson, Mayo Clinic; Nancy Wengenack, Mayo Clinic; Priya Sampathkumar, Mayo Graduate School of Medicine

Background: *Candida auris* is a globally emerging, multidrug-resistant fungal pathogen that causes serious, difficult-to-treat infections in hospitalized patients. *C. auris* cases in the United States have been linked to receipt of healthcare overseas. Outbreaks have also occurred in New York City, New Jersey, Chicago, and most recently in California. We provide care to patients from all 50 states and 138 countries; therefore, we are at risk for encountering *C. auris* in our facility. **Setting:** An academic, tertiary-care center with 1,297 licensed beds and >62,000 admissions each year. **Methods:** Infection prevention and control (IPAC) initiated a *C. auris* screening program in August 2019 in partnership with the State Health Department. A case-finding tool was created to identify adult patients admitted in the previous 24 hours from countries and areas of the United States (Chicago, New Jersey, and New York metropolitan areas) with known *C. auris* transmission based on the zip code of their primary address. IPAC sends an electronic communication via the electronic medical record (EMR) alerting the patient care team that the patient meets criteria for screening along with information on *C. auris* and links to a tool kit with additional resources to help answer questions. After obtaining verbal consent, the patient's primary nurse collects a composite axilla–groin skin swab using a nylon-flocked swab (BD ESwab collection and transport system; Becton Dickinson, Sparks, MD). The sample is sent to the State Health Department laboratory for testing by polymerase chain reaction (PCR). Results are communicated back to IPAC and then scanned into the patient's EMR. **Results:** From August 2019 to November 2019, 157 patients were identified for *C. auris* screening using the case-finding tool. Testing was performed on 95 patients; all tests were negative. The primary reasons for testing not to be performed on eligible patients were inability to obtain verbal consent and patient dismissal before sample could be obtained. The need for a special swab that is not routinely stocked on patient care units has been a limitation to timely specimen collection. **Conclusions:** The EMR can be leveraged for early identification and screening of patients at risk of *C. auris* colonization. Case finding tools can be effectively replicated and modified to respond to emerging infections and changing surveillance guidelines.

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Presentation Type:
Poster Presentation

Implementing an Automated Pneumonia Surveillance System

Dan Ding, NYU Langone Health; Michael Phillips, NYU Langone Medical Center; Eduardo Iturrate, NYU Langone Health; Sarah Hochman, NYU Langone Health; Anna Stachel, NYU Langone Health

Background: Although definitions from the CDC were developed to increase the reliability of surveillance data, reduce the burden of surveillance in healthcare facilities, and enhance the utility of surveillance data for improving patient safety, the algorithm is still laborious for manual use. We implemented an automated surveillance system that combines 2 CDC pneumonia surveillance definitions to identify pneumonia infection in inpatients. **Methods:** The program was implemented at an academic health center with

Variables	Description
MRN	Medical record number
MAX_TEMPERATURE	Daily maximum temperature
Record_Date	Date of temperature recorded
WBC	Result of White Blood Cell Count
Collection_Date	Collection date of WBC
Narrative	Narrative of Chest X-ray
Impression	Impression of Chest X-ray
CSN	A unique identifier for each patient visit
HOSP_ADMSN_DATE_TIME	Hospital admission date
HOSP_DISCH_DATE_TIME	Hospital discharge date
PROC_END_TIME	Exam end time of Chest X-ray
Type	Clinical note type included("Progress Notes", "Consults", "Treatment Plan", "Follow-up - Rehab Therapy")
Text	Contents of the Clinical notes
ServiceInstant	Service date of clinical notes
PerformedDtm	Collection date of microbiology cultures

Table 1.Variables used to drive our algorithm.

Table 1.

>40,000 inpatient admission per year. We used Window Task Scheduler with a batch file daily to run a validated pneumonia surveillance algorithm program written with SAS version 9.4 software (SAS Institute, Cary, NC) and a natural language processing tool that queries variables (Table 1) and text found in the electronic medical records (EMR) to identify pneumonia cases (Fig. 1). We uploaded all computer-identified positive cases into a Microsoft Access database daily to be reviewed by a hospital epidemiologist. Every week, we also validated 5 computer-identified "negative" cases from the prior 2 weeks to ensure accuracy of the computer algorithm. We defined negative cases as pneumonia present on admission or chest x-ray indicative of pneumonia but without CDC-defined surveillance symptoms. We also wrote a program to automatically send e-mails to key stakeholders and to prepare summary reports. **Results:** Since November 2019, we have successfully implemented the automated computer algorithm or program to notify, via e-mail, infection prevention staff and respiratory therapy providers of CDC-defined pneumonia cases on a daily basis. This automated program has reduced the number of manual hours spent reviewing each admission case for pneumonia. A summary report is created each week and month for distribution to hospital staff and the Department of Health, respectively. **Conclusions:** The implementation of an automated pneumonia surveillance system proves to be a timelier, more cost-effective approach compared to manual pneumonia surveillance. By

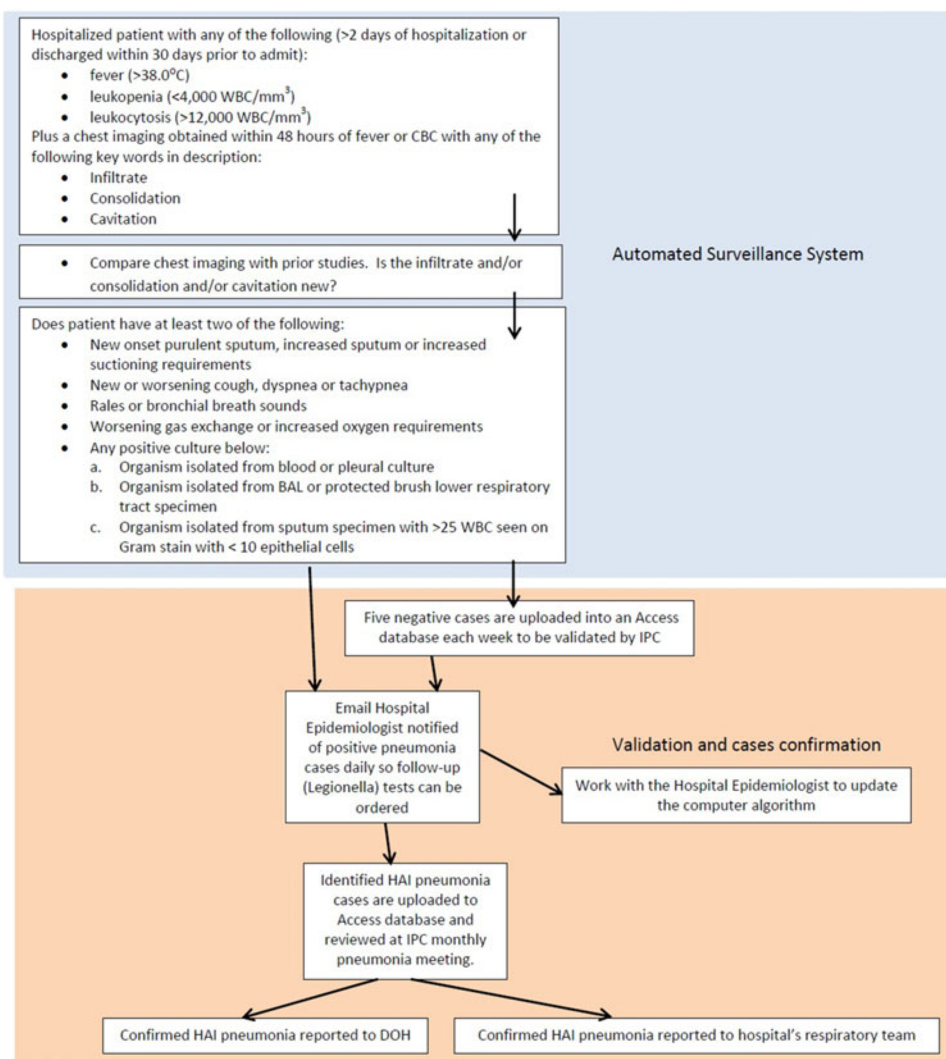

Fig 1. HAI Pneumonia Surveillance Algorithm

Fig. 1.

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allowing an automated algorithm to review pneumonia, timely reports can be sent to infection prevention control staff, respiratory therapy providers, and unit staff about individual cases. Hospitals should leverage current technology to automate surveillance definitions because automated programs allow near real-time identification and critical review for infection and prevention activities.

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Table 1: Prevalence Day Data

Direct Admissions: n=609	N (%)
Home	458 (75)
OSH	70 (12)
SNF or LTAC without tracheostomy or on ventilator	42 (7)
SNF or LTAC with tracheostomy or on ventilator	7 (1)
Unable to Obtain/Unknown	13 (2)
Declined to answer	19 (3)

Table 1.

Presentation Type:
Poster Presentation

Implementing an Electronic Screening Tool to Identify Patients at Risk for *Candida auris*

Christina Silkaitis, Northwestern Medicine; Lea Ann Arnold, Northwestern Medicine; Anessa Mikolajczak, Northwestern Medicine; Elizabeth Makula, Northwestern Medicine; Asra Salim, Northwestern Medicine; Anne Stehlik, Northwestern Medicine; Cindy Barnard, Northwestern Medicine; Gina Dolgin, Northwestern Medicine; Heather Voss, Northwestern Medicine; Chao Qi, Northwestern Medicine; Teresa Zembower, Northwestern Medicine

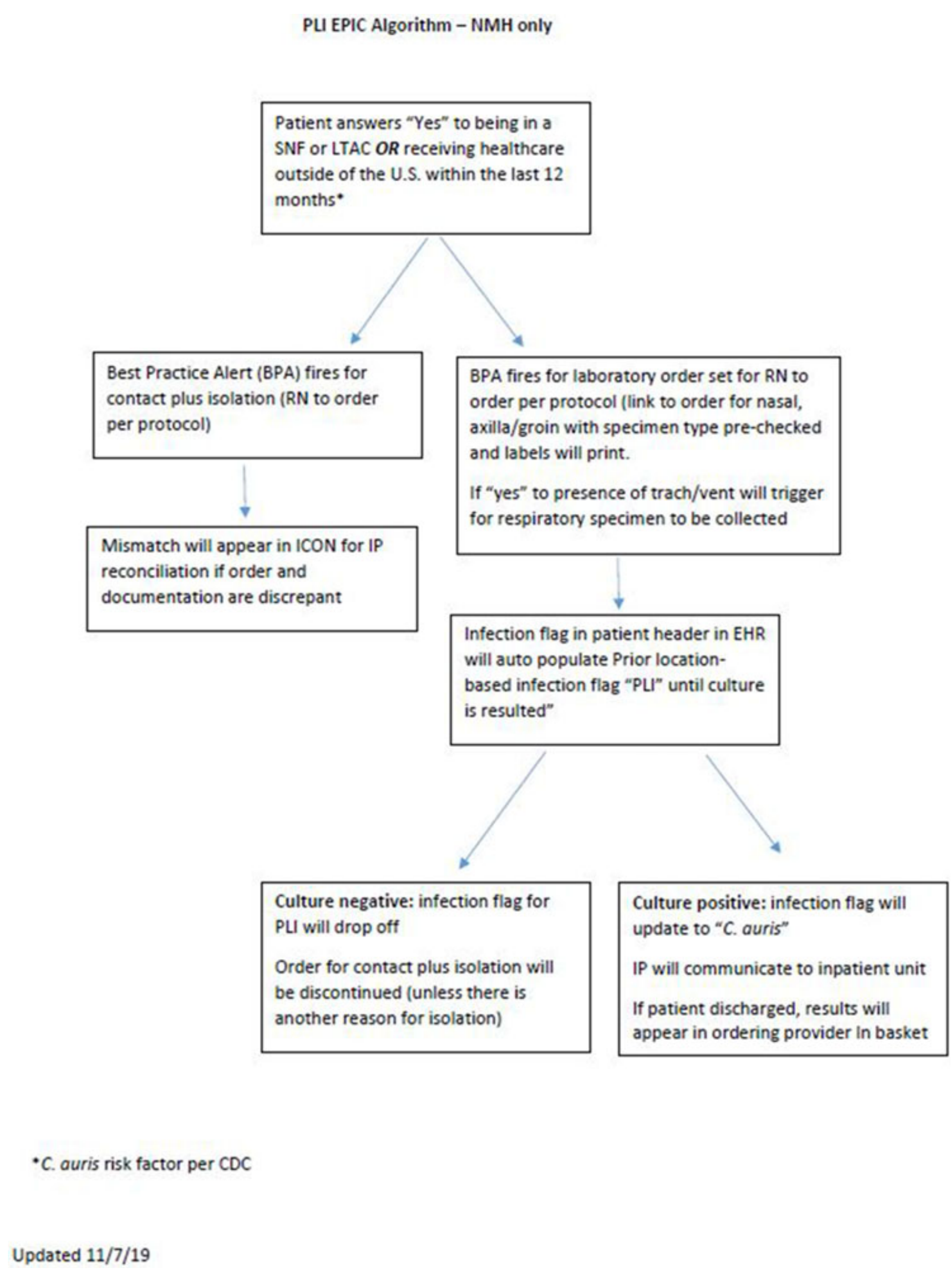

Fig. 1.

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