

Fig. 2.

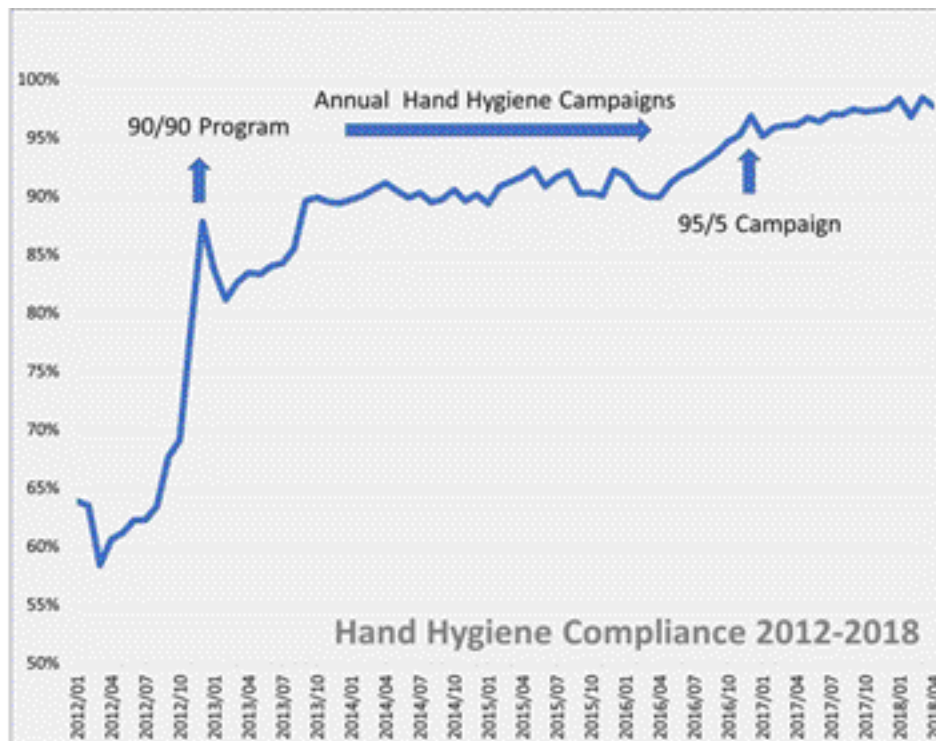


Fig. 3.

WHO 5 Moments was implemented throughout 2018, (in addition to the “In & Out” program). This intervention also incorporated elements of the WHO Multimodal Strategy 1 to develop a comprehensive hand hygiene program together with new indicators. The ABC Medical Center, with the support and leadership of the Ministry of Health, aims to become an example of institutions that achieve national and international benchmarks in the implementation of patient safety programs that are not only successful but also sustainable.

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Presentation Type:

Poster Presentation

Hand Hygiene in Acute Care Hospitals—Evaluation of 12 Years National Hand Hygiene Campaign in Germany

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Background: Hand hygiene is one of the most effective measures to prevent healthcare-associated infections and transmission of multi-drug-resistant organisms in healthcare settings. The WHO proposes a multimodal intervention strategy to improve hand hygiene in healthcare settings. In 2008, a voluntary national campaign for hand hygiene was implemented in the German healthcare system. The objective of this study was to evaluate participation, practices, and performance of hand hygiene in German acute-care hospitals. **Methods:** In 2008 a national hand hygiene campaign began in Germany. Based on voluntary participation, the campaign's goal was to implement the WHO 5 Moments model, to establish a national surveillance system for compliance to hand hygiene, to improve availability of alcohol-based hand-rub (ABHR) dispensers at points of care, and to implement interdisciplinary executive boards at each hospital to ensure sustainable implementation. Annual data on ABHR consumption and patient days (PD) were collected within the national surveillance system (HAND-KISS) on the individual ward level and were validated. Direct observation of compliance was performed according the recommendations of the WHO. **Results:** Overall, 1,047 of 1,942 acute-care hospitals in Germany participated in the national hand hygiene campaign in 2018, covering 81,571,917 patient days. Moreover, 9,360 regular wards (RWs), 338 intermediate care units (IMCs) and 1,342 intensive care units (ICUs) provided data on ABHR consumption. Between 2007 and 2018 in the ICU, ABHR consumption increased continuously from 70 mL/PD (IQR, 52–98) to 129 mL/PD (IQR, 102–162). In intermediate care units, ABHR consumption increased from 40 mL/PD (IQR, 15–54) to 67 mL/PD (IQR, 46–95), and on regular wards, ABHR consumption increased from 14 mL/PD (IQR, 10–21) to 29 mL/PD (IQR, 22–39). These increases were especially pronounced in wards that continuously provided annual data for ABHR consumption over the past 12 years. In 2014, electronic documentation for direct observation of compliance to hand hygiene was established. From 2014 until 2018, 1,598,209 opportunities were observed on 1,907 wards of 422 hospitals. The median directly observed compliance in 2018 was 76% (IQR, 66%–84%). Median compliance to the 5 Moments was 71% (IQR, 57%–82%) before touching a patient, 68% (IQR, 51%–85%) before clean or aseptic procedures, 83% (IQR, 72%–92%) after body fluid exposure or risk, 84% (IQR, 75%–90%) after touching a patient, and 74% (IQR, 61%–84%) after touching patient surroundings. **Conclusions:** The WHO multimodal intervention strategy has been successfully established in German acute-care hospitals. A surveillance system for ABHR consumption and direct observation of compliance to hand hygiene are widely used by hospitals in Germany. Hand hygiene practices have significantly improved in the German healthcare system.

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Has UTI and *Clostridioides difficile* Testing and Treatment Stewardship Diffused Into Oregon Hospitals? A Survey of the Current State

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Background: Urinary tract infection (UTI) and *Clostridioides difficile* infection (CDI) both pose significant diagnostic challenges. Excess testing has implications for hospital-associated infection surveillance and may also lead to overtreatment and associated patient risk. Accurate diagnosis requires stewardship efforts to ensure that the correct patients are tested appropriately. In coordination with clinicians and microbiology labs, hospital infection prevention departments can aid diagnostic stewardship efforts by creating policies for order indications and proper test collection methods and by developing electronic medical record (EMR) support for diagnostic and treatment algorithms. The prevalence of these practices in Oregon, however, is unknown. **Methods:** We deployed a web-based survey to infection preventionists at all 61 acute-care hospitals in Oregon in January 2019. Responses were collected through April 2019, and a subset of applicable questions were analyzed. **Results:** Of 61 acute-care hospitals, 58 (95%) responded. A response from a single long-term acute-care hospital was excluded. For urinary tract infections (UTIs), a minority of hospitals reported having policies requiring annual sterile urine collection training for registered nurses (n = 7, 12%), annual observation of the RN sterile urine collection procedure (n = 1, 2%), or use of boric acid containers for urine collection (n = 10, 17%). UTI testing and treatment algorithms embedded in the electronic medical record (EMR) were more common (Fig. 1). Regarding urine culture reflex policies, 39 facilities (68%) reported reflexing abnormal urinalyses to culture only if ordered, whereas 14 respondents (25%) reported automatically reflexed all abnormal urinalyses to culture. For *Clostridioides difficile* infection (CDI), respondents reported using a variety of methods to discourage inappropriate testing (Fig. 2). Although almost all facilities (n = 53, 93%) reported having a policy to reject formed stool, less than half (n = 27, 47%) reported having a policy to reject stool in patients receiving laxatives. Furthermore, 74% of respondents (n = 42) had a published testing algorithm, more than twice the 18 (32%) hospitals that reported having a comparable UTI algorithm. **Conclusions:** Infection prevention departments in Oregon acute-care hospitals utilize a variety of tools to contribute to diagnostic and treatment stewardship for UTI and CDI. Our survey revealed many opportunities for improvement in UTI and *C. difficile* testing and treatment stewardship in Oregon hospitals. For example, although most hospitals reject formed stool for CDI

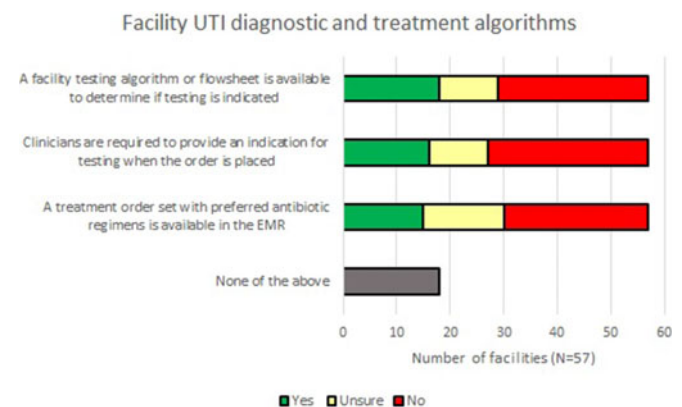


Fig. 1.