antibiotic was the most sensitive (97%) but least specific (65%) indicator. There was variability in indicator performance between procedure types. Readmission to the hospital was more sensitive in procedures with implants, e.g. KPRO and HPRO, than in procedures without, such as COLO and HYST. Evaluating the performance of possible SSI indicators enables IP programs to make data-driven and pragmatic decisions related SSI case finding practices. Tuning the indicator criteria within the software build may be necessary for optimization and presents an opportunity for IP time and cost savings.

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Poster Presentation
Subject Category: Surveillance
Experience of a Northern California Acute Care Hospital in Active Surveillance for Candida auris

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Background: Candida auris is an emerging fungal pathogen with potential to cause outbreaks. To mitigate transmission, the California Department of Public Health (CDPH) recommends considering implementation of an active case detection process in acute care hospitals to identify high-risk patients who may be colonized on admission. **Methods:** From 1/5/2024 to 9/20/2024, Stanford Health Care piloted an active surveillance program to identify high-risk patients for C. auris – defined as patients coming from (1) long term acute care hospitals (LTACHs), (2) ventilator skilled nursing facilities (vSNFs), (3) outside institutions with known C. auris outbreaks, (4) hospitals in Nevada, (5) recent international hospitalizations, and (6) patients with carbapenemase-producing organism (CPO) colonization. Patients were identified for screening via daily review of custom-designed lists from the electronic medical record (EMR). A list of patients admitted from skilled nursing facilities (SNFs) and a list of patients transferred to Stanford from an outside facility were cross-referenced with a published list of high-risk facilities provided by CDPH. A list of inpatients flagged for CPOs was reviewed daily. Infection prevention was also notified by the transfer center or the care team if a patient had a recent international hospitalization. Screening was via superficial skin specimens from the axilla and groin. Culture-based testing was performed with identification of any fungal growth via MALDI-TOF. **Results:** During the pilot period, 1159 patients were evaluated for high-risk criteria; 58 (5%) met criteria for C. auris testing. One of 58 patients (colonization (Figure 1). There were 5 clinical cases during the pilot period, including the patient identified via screening. Active surveillance required 5-7 hours per week of infection preventionist effort, plus an hour to educate nursing staff when screening tests were performed. **Conclusions:** Our experience with performing active surveillance for C. auris resulted in one positive case, suggesting that this approach may have a lower yield in regions with low prevalence. Since surveillance can often be a time-intensive task for infection preventionists and nursing staff, it is important we continue to improve our knowledge about when and what surveillance is the most effective.

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Antimicrobial Resistant Organism Admission Screening Adherence Using a Clinical Information System in a Provincial Healthcare System

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Background: Targeted admission screening of high-risk patients for antimicrobial resistant organisms (AROs) is a key component of infection prevention and control. However, adherence with screening is suboptimal, risking a negligible impact on the prevention of ARO transmission. Clinical decision support tools in clinical information systems (CIS) may improve ARO screening adherence. This study evaluated the adherence of ARO admission screening using a tool in the provincial CIS in Alberta, Canada and the relationship between adherence and hospital ARO rates. **Methods:** A population-based, sequential cross-sectional study was completed on all admissions to acute care and acute rehabilitation facilities where ARO admission screening occurs on any unit, and where the CIS was implemented in Alberta between January 1, 2020 and March 31, 2024 (n=100). Mental health facilities/units, continuing care, newborns **Results:** There were 97 (97% of eligible facilities) facilities that implemented the CIS across seven launch periods included. Overall adherence ranged from 43% to 65%. After controlling for bed size and health zone, adherence decreased by the number of months each facility was active on the CIS (aIRR 0.987, 95%CI 0.986-0.987). There was no seasonality in trends. There was a negative relationship between adherence and overall MRSA infection rate (rs = -0.68) and after adjusting for bed size, health zone, and number of months active on the CIS (aIRR 0.99, 95% CI 0.986-0.994). Analysis could not be completed for CPO due to small numbers. **Conclusions:** While increased ARO admission screening adherence was associated with lower overall MRSA infection rates, the IRR was close to one and may not be clinically significant. With adherence decreasing over time, further work is needed to understand barriers to ARO admission screening and implement strategies to support healthcare providers in completing appropriate surveillance for AROs.

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Figure 1. Flow diagram of patients identified for *C. auris* screening between 1/5/2024 and 9/20/2024