

Presentation Type:

Poster Presentation - Poster Presentation

Subject Category: Surveillance**Carbapenemase-Producing Enterobacteriaceae detected in a Large Canadian Tertiary Care Hospital: Five-year retrospective study**

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Background: The prevalence of carbapenemase-producing Enterobacteriaceae (CPE) is increasing worldwide. In Canada, where rates of healthcare-associated (HA) transmission of CPE remains relatively low, there is a need to share early experience of universal screening programs and risk factors for HA acquisition. **Method:** In 2018, universal screening was introduced throughout our large Canadian tertiary care hospital across, all critical care and oncology units. Additionally, risk-factor based screening was applied in all other inpatient units, with further targeted screening of roommate exposures or all inpatients on unit following identification of a single HA case. A retrospective cohort study was carried out on CPE cases detected between January 2018 and December 2023. We assessed the proportion of HA CPE cases, defined as CPE identified in patients with prior admission to our facility or after >72 hours after admission. HA cases were examined for relevant risk factors, including known roommate with CPE, the presence of other CPE on the unit, exposure to outbreak units, prior travel history, travel by a family member, and antibiotic exposure within the past 90 days. **Result:** A total of 150 CPE cases were identified, with 66 (44%) classified as HA. Among these HA cases, 14 (21%) were associated with presence of known case on the unit. The remaining 52 (79%) represented sporadic nosocomial cases without a known exposure or further transmission on the unit. Upon further retrospective review, 6 (9.2%) HA cases had documented travel history or exposure to a family member with recent travel to China, India, Sri Lanka, or the United States within the past year. Nearly all HA cases (62, 95.4%) had antibiotic exposure within 90 days of CPE detection; specifically, 47 (72.3%) received beta-lactams, 42 (64.6%) cephalosporin, 25 (38.5%) glycopeptide, 20 (30.8%) carbapenem, and 8 (12.3%) macrolide. **Conclusion:** HA CPE acquisition identified during the first 5-years of universal screening were mostly sporadic and not associated with known exposures or other risk factors. Receipt of prior antibiotics was present in nearly all cases.

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Subject Category: Surveillance**From Swiffers to Solutions: The Impact of Environmental Sampling in the Veterinary Medical Center at OSU**

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Background: In 2018, the Ohio State University College of Veterinary Medicine (OSU CVM) implemented an Antimicrobial Stewardship Program, central to which was the integration of an environmental surveillance (ES) program. The ES focuses on pathogens recognized as urgent threats to public health by the Centers for Disease Control and

Prevention. The pathogens currently targeted include carbapenemase-producing Enterobacteriales (CPE), Salmonella spp., methicillin-resistant Staphylococcus spp. (MRSSs), vancomycin resistant Enterococcus spp., and enrofloxacin resistant Pseudomonas aeruginosa. Identification of these pathogens allows the hospital to be aware of the local environmental microflora which can act as a sentinel for disease in the hospital, potentially causing healthcare associated infections. Therefore, the objective of this program is to identify resistant bacterial pathogens, characterize their resistance profiles, analyze prevalence patterns, and initiate infection control interventions where needed in the OSU VMC. **Method:** From January 2018 through December 2023, a total of 5449 samples were collected from approximately 86 locations across the OSU VMC encompassing the small animal, equine, and farm animal sections. A majority (64%, n=3561) of samples were collected from the small animal hospital, with the farm animal section contributing 1055 samples and the equine section 899. Areas sampled were frequented by both humans and animals, as well as surfaces exclusively touched by humans. Samples were collected using Swiffers® and processed through selective culture media. **Result:** Approximately half (52%, n=2890) of the samples collected represented human-touch only surfaces. A total of 3794 bacterial isolates were recovered, with an overall low prevalence for all targeted pathogens. Prevalence of CPE was 2% (n=103), with Enterobacter species being the most common. Recovery of MRSSs was 8.5% (n=464) and Salmonella species was 1% (n=47). **Conclusion:** Through this initiative, the equine division of the OSU VMC collaborated with the antimicrobial stewardship team to enhance their Salmonella fecal and ES practices. In 2019, ES was critical in identifying persistent CPE and extended-spectrum cephalosporin-resistant Enterobacteriaceae in the ICU and surrounding areas of the small animal hospital. Effective measures were taken to halt the spread of ESC among patients and eliminate CPE in the environment. With the discovery of a new CPE in early 2023 in the small animal ICU and nearby areas, the program initiated targeted ES and cleaning and disinfection protocols, to identify contaminated areas and control disease transmission. These efforts have increased patient safety, health, and well-being, demonstrating how ES can be an important tool for infection control and prevention in veterinary settings.

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Subject Category: Technology**An “Epic” Journey to Improve Antimicrobial Stewardship**

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Background: Antimicrobial stewardship programs rely heavily on the electronic medical record (EMR) to carry out daily activities, make interventions, optimize patient care, and collect data. In 2019 the University of Vermont Medical Center transitioned from using a third party platform to the Epic (Verona, WI, www.epic.com) Bugsy module for antimicrobial stewardship. **Method:** We have spent the past 4 years optimizing the Epic foundation to match our institutional antimicrobial prescribing guidelines, susceptibility patterns, and build reports to extract actionable data. **Result:** During the build process, we readily identified three areas needed for customization: (1) Empiric, definitive, and prophylactic indications of use for all antimicrobials based on our hospital’s internally published books “Guide to Antimicrobial Therapy for Adults” and “Guide to Antimicrobial Therapy for Pediatrics” (figure 1); (2) An on-demand report to capture all patients with new administrations of antimicrobials in the preceding 72 hours, that includes

Figure 1: Customized antimicrobial order entry matching UVMC’s internal antimicrobial prescribing guide

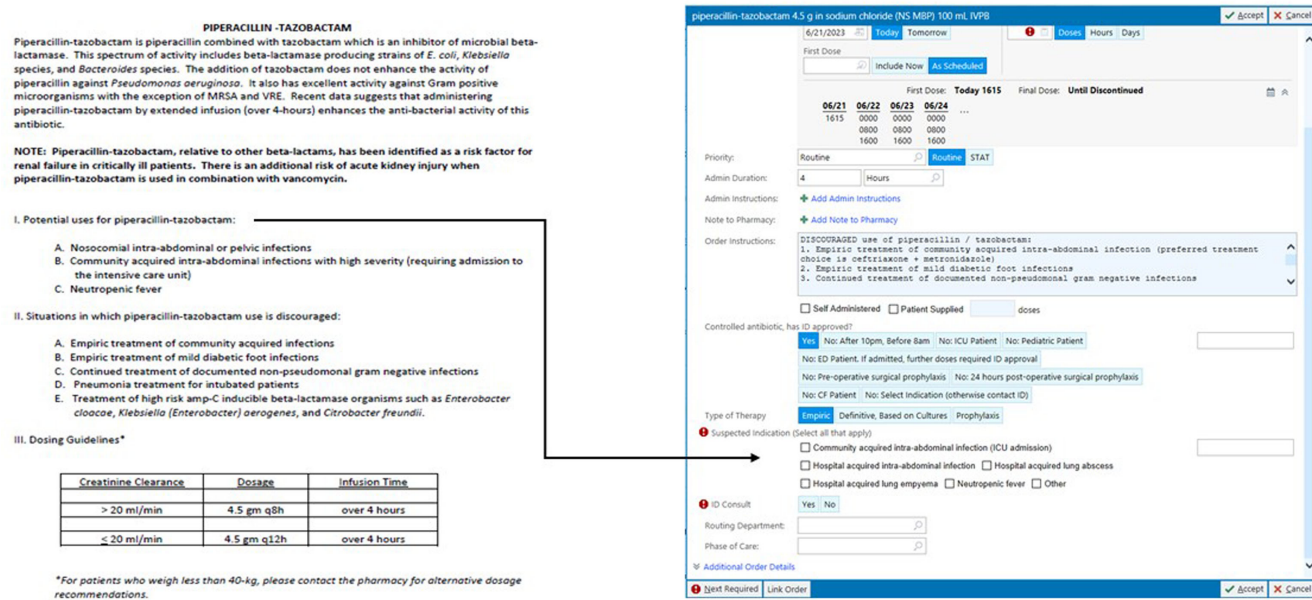
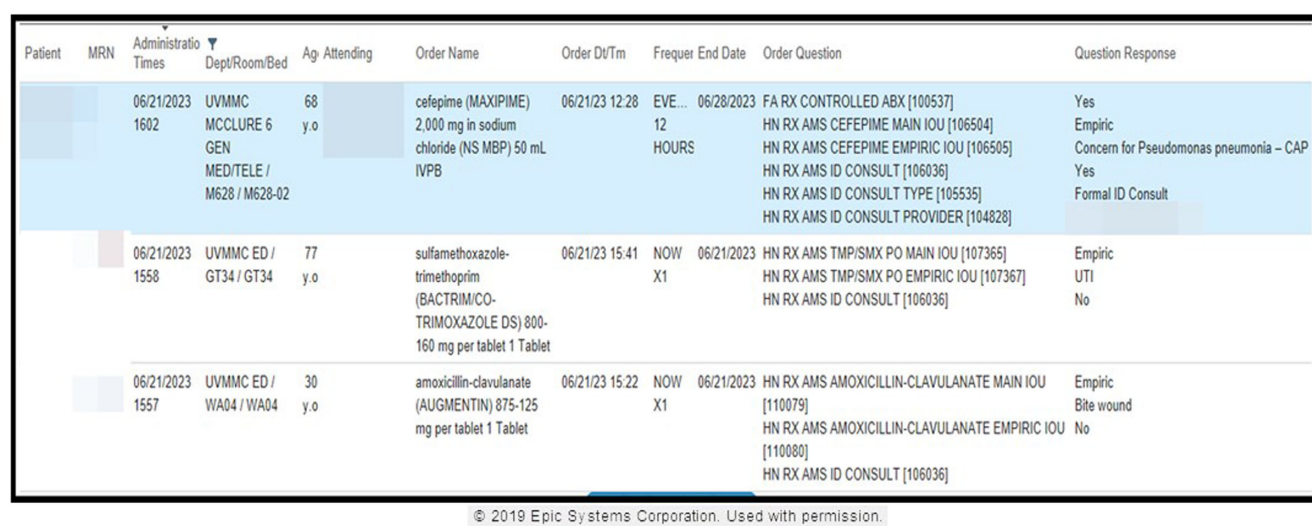


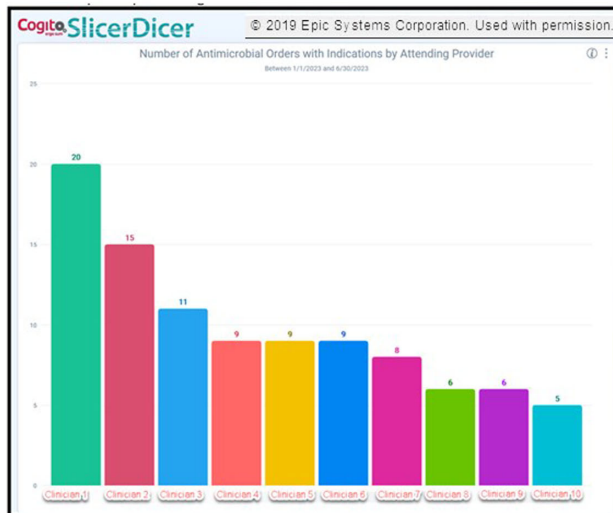
Figure 2: A unique on-demand report for all hospitalized patients receiving at least one dose of an antimicrobial agent in the past 72 hours



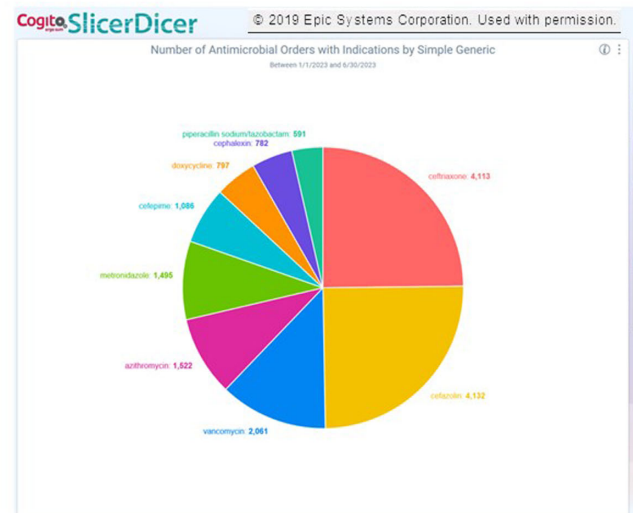
ordering clinician, stop date of therapy, and indication (figure 2); and (3) A unique, custom-built slicer-dicer report to capture high-level data on how each antimicrobial is being prescribed by indication, dose, route of administration, ordering clinician, attending physician, and department (figure 3). **Conclusion:** We have built a system where we can readily identify patients that are receiving antimicrobials both within and outside of institutional guidelines and know the ordering clinician

to contact to provide in-the-moment feedback. We can also collect retrospective data to know which antimicrobial agents were prescribed for all infectious syndromes. These three institutional customizations have provided invaluable information to improve patient care.

Figure 3: A custom-built SlicerDicer model to capture antibiotic usage data and prescribing practices.



Number of patients administered cefepime in the UVMHC MICU by attending physician.



Top 9 prescribed antimicrobials at UVMHC.

Presentation Type:

Poster Presentation - Poster Presentation

Subject Category: Water Management

Chlorine levels and a Legionella outbreak

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Background: Legionella, first identified in the 1970s, is increasingly recognized as an opportunistic pathogen in healthcare facilities.¹ The National University Hospital (NUH) is a large quaternary level academic hospital with 1,200 beds located in equatorial Singapore. Its first building, completed in 1985, still serves patients today. In 2022, the infection prevention team (IPT) was informed of two cases of nosocomial legionella, which sparked the start of an extensive investigation consisting of water quality testing of multiple sources, case finding, and formation of a water management committee. **Methods:** 250mL water samples were collected and cultured by an external vendor using direct membrane filtration followed by plating on selective agar according to ISO 11731 standards. Bacterial

colonies were then identified, quantified and speciated. At the same time, NUH's facility management measured chlorine levels using a portable colorimeter. **Results:** In total, we cultured 34 samples taken from sinks, shower heads, potable water dispensers. 91.2% of samples were positive for legionella. Of the 91.2%, 35.3% of sites grew Legionella pneumophila serogroup 1 while 79.4% of sites grew Legionella pneumophila serogroup 2-15. We attributed our high rates of legionella positivity to an aging plumbing system and Singapore's high humidity and temperatures. In addition, the maximal temperature of our hot water is only 48-50 °C. Although chlorine levels were generally low, they were still within the local recommendation of less than 2ppm (Singapore does not have guidance on minimum chlorine levels). We found no statistically significant correlation between the number of legionella colony forming units (CFUs) and chlorine levels (ranging between 0.02 to 0.14ppm). This supports the United States Environmental Protection Agency's recommendation, as well as the findings from in vitro and in vivo studies, for a minimal chlorine of 0.2 PPM at the taps for acute care hospitals.^{2,3} However, these levels may be inadequate in the presence of acanthamoeba or a high biofilm load within water systems.^{4,5} **Conclusion:** Hospital water management programs should require a minimal level of chlorine at hospital taps and at levels above those recommended by public water systems, in order to control legionella growth. In addition, the formation of a hospital water management committee is essential to improve hospital water quality and put mitigation measures in place. References 1. Phin, N. et al. Epidemiology and clinical management of Legionnaires' disease. Lancet Infect. Dis. 14, 1011–1021 (2014). 2. Marchesi, I. et al. Monochloramine and chlorine dioxide for controlling Legionella pneumophila contamination: biocide levels and disinfection by-product formation in hospital water networks. J. Water Health 11, 738–747 (2013). 3. Cervero-Aragó, S., Rodríguez-Martínez, S., Puertas-Bennasar, A. & Araujo, R. M. Effect of Common Drinking Water Disinfectants, Chlorine and Heat, on Free Legionella and Amoebae-Associated Legionella. PLoS One 10, e0134726 (2015). 4. Kessler, M. A., Osman, F., Marx, J., Pop-Vicas, A. & Safdar, N. Hospital-acquired Legionella pneumonia outbreak at an academic medical center: Lessons learned. Am. J. Infect. Control 49, 1014–1020 (2021).

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