who received VPT to VCT for surgical prophylaxis. Patients receiving other surgical prophylaxis regimens due to allergy or colonization history were excluded. Donor and recipient culture data from bronchoscopy samples were collected to determine the incidence of *Pseudomonas* in the 14-day post-transplant period. The secondary outcome was the incidence of post-transplant CDC-defined pneumonia. Statistical analysis was performed using SAS 9.4 (Cary, NC).

**Results.** One hundred patients were included in the pre-proto-group (VPT), and 65 in the post-proto-group (VCT). *Pseudomonas* was recovered in recipient BAlS on post-op day 2-14 in 8% (8 patients in the VPT group compared with 5.7% (7 patients) in the VCT group (P = 0.8). Mean time to VPT isolation was 8.4 days in the VPT group compared with 5.4 days in the VCT group. Incidence of pneumonia on post-op day 2-14 was 6% in the VPT group vs. 3% in the VCT group (P = 0.48). Surgical site infections were rare in the VCT group with an incidence of 1.5% (1/65).

**Conclusion.** Isolation of *Pseudomonas* was rare in both time periods and an increase was not detected when anti-pseudomonal coverage was removed from the surgical prophylaxis regimen. Safe desescalation of surgical prophylaxis regimens are an important antimicrobial stewardship initiative.

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2139. Improving Peri-Operative Skin Prep Technique at a Large Tertiary Medical Center: A Quality Improvement and Educational Initiative

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**Session:** 235. Healthcare Epidemiology: Surgical Site Infections

**Saturday, October 6, 2018: 12:30 PM**

**Background.** Surgical site infections (SSIs) are the most common cause of health-care-associated infections. As part of our campaign to reduce SSIs at UT Southwestern Medical Center in Dallas, TX, we sought out to audit skin prep practices with the initial focus on application technique and a secondary focus on choice of product.

**Methods.** In preparation for the universitY’s audits an appropriate-ness of skin prep for compliance with manufacturer’s directions and whether sufficient drying time was allowed. Skin prep was done appropriately less than 50% of the time. BD assessed skin prep practices in May 2017 using a standardized observation tool that evaluated method of application and compliance to time to dry prep. We were able to simplify the various products available to surgical staff, provide consistent recommendations on directions for use. Inservice training programs were developed. Nursing educators developed an audit and competency tool for monitoring.

**Conclusion.** The correct application technique, prep time and dry time were adhered to in <50% of the observations. Of interest is that national averages for all of the products measured and compliance was calculated as a percentage.

**Results.** A total of 51 cases were observed. Chloraprep was used most often, followed by two-step PVP Scrub and Paint, CHG and DuraPrep. Chloraprep was applied correctly 44% of the time and DuraPrep 6% of the time. Chloraprep prep time was compliant only 6% of the time. Dry time compliance was 45% for Chloraprep and 50% for DuraPrep. Overall application method was correct 41% of the time, proper prep time 3% (compared with a national average of 44%), proper dry time of 41%. A skin prep task force worked to simplify the products available and changed recommendations for use. Inservice training programs were developed. Nursing educators developed an audit and compliance tool for monitoring.

**Conclusion.** The correct application technique, prep time and dry time were adhered to in <50% of the observations. The correct application technique was performed in 102 patients (53%). Culture of material samples taken during surgery were plurimicrobial in 67 patients (34%). After surgery, the median follow-up of patients was 7.5 months (IQR: 2–19) during which 30 presented a failure (15%) and 85 patients died, 41 due to the PVGI (21%). Factors independently associated with multivariate and this were: to be 60 years old (OR = 8.2; P < 0.01), to stay in ICU for more than 6 days (OR = 5.9; P = 0.01) and to have an intracavitary PVGI (OR = 9.0; P = 0.02). Antibiotic therapy regimen combining rifampicin to another antibiotic was associated with a decreased mortality (OR = 0.13; P < 0.01).

**Conclusion.** Our results suggest that the prognostic of patients admitted for PVGI depends on the site of infection and the occurrence of a shock after the admission. We found a better prognosis for patients with an extracavitary PVGI, without septic shock. Finally, PVGI treated with an antibiotic combination including rifampicin had a better outcome.

**Disclosures.** All authors: No reported disclosures.

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2141. Characteristics and Prognosis of Patients with a Prosthetic Vascular Graft Infection (PVGI) (PVGI): A Prospective Cohort of 200 patients

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**Session:** 235. Healthcare Epidemiology: Surgical Site Infections

**Saturday, October 6, 2018: 12:30 PM**

**Background.** The aim of the present study was to describe the characteristics and prognosis of patients admitted for a PVGI and to assess the factors associated with the outcome of the treatment.

**Methods.** All consecutive patients admitted in our department between January 1, 2000 and January 1, 2018 for a PVGI were enrolled in the present prospective cohort study. P V G I s were divided into extravascular (femoro-femoral, femoro-popliteal and axillo-femoral) and cavitary (aorto-iliae, aorto-femoral, ilio-femoral, aorto-cavital). In “early” infection (<4 months) and late. Patients’ baseline characteristics and their follow-up were described, and factors associated with death were assessed using a logistic multivariate regression model.

**Results.** Overall, 200 patients were included during this period. The median age of patients was 69 years (IQR: 61–78), mainly of men (86%). One hundred and sixteen patients had an intracavitary PVGI (58%). Enterobacteriaceae and MSSA were the most frequent pathogens (n = 60 and 59), followed by coagulase negative staphylococci (n = 30), Streptococcus (n = 26) and enterococcus (n = 25). Surgery with explantation was performed in 67 patients (33%). Culture of material samples taken during surgery were plurimicrobial in 67 patients (34%). After surgery, the median follow-up of patients was 7.5 months (IQR: 2–19) during which 30 presented a failure (15%) and 85 patients died, 41 due to the PVGI (21%). Factors independently associated with multivariate and this were: to be 60 years old (OR = 8.2; P < 0.01), to stay in ICU for more than 6 days (OR = 5.9; P = 0.01) and to have an intracavitary PVGI (OR = 9.0; P = 0.02). Antibiotic therapy regimen combining rifampicin to another antibiotic was associated with a decreased mortality (OR = 0.13; P < 0.01).

**Conclusion.** Our results suggest that the prognosis of patients admitted for PVGI depends on the site of infection and the occurrence of a shock after the admission. We found a better prognosis for patients with an extracavitary PVGI, without septic shock. Finally, PVGI treated with an antibiotic combination including rifampicin had a better outcome.

**Disclosures.** All authors: No reported disclosures.

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2142. Understanding Errors in Sterile Processing of Surgical Instruments That Lead to Need for Immediate Use Sterilization in the Operating Room

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**Session:** 235. Healthcare Epidemiology: Surgical Site Infections

**Saturday, October 6, 2018: 12:30 PM**

**Background.** “Flash sterilization”, an outdated term for immediate-use sterilization. Immediate use is broadly defined as the shortest possible time between a sterilized item’s removal from the sterilizer and its aseptic transfer to the sterile field for use in the procedure for which it was sterilized, but at our institution, immediate-use sterilization of individual unwrapped objects has a very specific definition: this is a vacuum sterilization performed in a pre-vacuum sterilizer (as opposed a gravity displacement steam sterilizer). A complete cycle is composed of a 4-minute exposure