Results. 22 patients with median age of 74 years old were identified, only three pediatric cases. The average time of acquired influenza was at 13th day of hospitalization. In 77% Influenza A was the only agent detected and 27% had respiratory co-infection. Thirteen (59%) were previously hospitalized in CCU, but only 2 (15%) due to respiratory problems. Nineteen patients (86%) presented comorbidity such as arterial hypertension (59%), chronic kidney disease (18%), and immunosuppression (18%). Half of them had a decompensation, mainly respiratory, associated to influenza infection. The observed lethality was 18%. Among all the influenza HAI, 59% occurred in unvaccinated patients, although 46% of them met criteria for vaccination recommendation.

Conclusion. HAI due to influenza occurred in chronic, older, and unvaccinated patients. Education about HAI’s and continuing high vaccination coverage must be a priority.

Disclosures. All authors: No reported disclosures.

1265. Application of the ALERT Influenza Trigger for Enhanced Prevention Activities
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Session: 139. Healthcare Epidemiology: Outbreaks
Friday, October 5, 2018: 12:30 PM

Background. Accurate prediction of the onset of increased influenza activity in a healthcare setting can allow for optimal use of enhanced prevention activities. The ALERT (Above Local Elevated Respiratory Illness Threshold) algorithm, described by Reich et al. (2015), utilizes historical weekly case counts of laboratory-confirmed influenza infections to set a trigger point of cases/week that anticipates elevated disease incidence. This can then be used in real-time, during subsequent influenza seasons, for initiation of enhanced prevention, including masking by nonvaccinated healthcare workers.

Methods. Historical data collected from UnityPoint Health-Des Moines (3-hospital, 800-bed system), between 2011 and 2014, was analyzed using the ALERT method (Reich et al. 2015) to set a threshold number of diagnosed influenza cases per week to predict the start of the influenza season. Each following year the threshold was reanalyzed, adding the most recent year’s data to the historical data set. Our goal was to capture at least 80% of influenza cases within our “ALERT period,” without prolonging the duration of heightened prevention efforts.

Results. For the initial year of real-time application (2015–2016), the threshold was defined as seven cases. In subsequent years, the threshold was 5. Compared with the 3 years prior, use of the ALERT method resulted in more accurate and consistent identification of the influenza season, including anticipating the increase in cases and defining the total duration of the season.

| Year          | Threshold | Onset Date of Enhanced Prevention | Total Cases Captured | Duration of Alert Period
|---------------|-----------|-----------------------------------|----------------------|---------------------------|
| 2012–2013     | N/A       | November 15, 2012                 | 725                  | 99%                       | 22                       |
| 2013–2014     | N/A       | December 30, 2013                 | 255                  | 77%                       | 9                        |
| 2014–2015     | N/A       | December 11, 2014                 | 773                  | 73%                       | 19                       |
| 2015–2016     | ALERT Trigger Initiated | February 22, 2016               | 250                  | 87%                       | 13                       |
| 2016–2017     | 7         | January 3, 2017                   | 791                  | 95%                       | 17                       |
| 2017–2018     | 5         | December 11, 2017                 | 1,445                | 98%                       | 20                       |

*As of April 28, 2018.

Conclusion. The ALERT method utilizes health system specific historical data to more precisely define the period of high influenza incidence allowing for focused utilization of enhanced measures to prevent transmission. This results in a safer environment, optimal use of resources and improved employee and patient satisfaction.

Disclosures. All authors: No reported disclosures.

1266. Multifaceted Infection Control Strategies to Control Multidrug-Resistant Aspergillus Infections in an Adult Intensive Care Unit in a Tertiary Hospital in Eastern Region, Saudi Arabia
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Session: 139. Healthcare Epidemiology: Outbreaks
Friday, October 5, 2018: 12:30 PM

Background. Multidrug-resistant Acinetobacter baumannii (MDR-AB) has emerged globally as a significant pathogen in hospitals. During 2010, our hospital experienced an increase of MDR-AB in Adult intensive care unit (ICU). Our adult ICU is consists of 10 acute care beds. The hospital is a tertiary institution located in Eastern region of Saudi Arabia. Multidisciplinary team was formed to implement and determine the effect of multifaceted strategies in controlling MDR-AB.

Methods. Active surveillance culture (ASC) was initiated to determine the prevalence rate of MDR-AB per 1,000 patient-days (PD). Using ASC, which was done during admission in ICU, after 48 hours of admission and every week for all patients if there is a positive MDR AB case, acquisition rate of MDR-AB was calculated per 1,000 PD.

Average daily colonization pressure was also monitored. In addition, a multifaceted infection control strategies were carried out. These include hand hygiene, contact isolation, cohorting of patients, Chlorhexidine bath, and environmental cleaning and disinfection. Compliance with hand hygiene was observed using direct observation method. We use the Fluorescent Gel Method for evaluating the thoroughness of disinfection and cleaning for environmental surfaces.

Results. Hand hygiene compliance of HCWs initially was 89%, in 2017 it was increased to 98%. Daily Chlorhexidine bath was adopted for all patients in ICU. Initially, the compliance for thoroughness of disinfection and cleaning was 84.6% it was increased to 92% in 2013–2017. Prevalence rate of MDR-AB was 20.7/1,000 PD in 2010, it was decreased by 50% in 2011–2012. In 2017, declined to 0.9/1,000 PD. MDR-AB acquisition rate was 11.8/1,000 PD in 2010, it was decreased by 57% in 2011–2012. In 2017, dropped to 0.6/1,000 PD. Average daily colonization pressure was 0.21 in 2010. In 2011–2012, it was decreased by 31%. In 2017, it was reduced to 0.02. Death rate among MDR-AB patient in 2010 was 25.7%. It was decreased to 14% in 2011–2012. In 2017, an enormous drop to 0% was achieved.

Conclusion. Implementing these multifaceted strategies help in controlling MDR-AB in our hospital. The commitment and adherence of the HCW to all infection control strategies are essential in sustaining low prevalence rate and acquisition rate of MDR-AB.

Disclosures. All authors: No reported disclosures.

1267. Nonventilator Hospital Acquired Pneumonia (NV-HAP) Prevention Initiative in Colombia, Bogotá
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Session: 139. Healthcare Epidemiology: Outbreaks
Friday, October 5, 2018: 12:30 PM

Background. Pneumonia is the second most common healthcare-associated infection worldwide. Non ventilator – Hospital Acquired Pneumonia (NV-HAP) affects more people than VAP, has a comparable mortality rate (18.7% vs. 18.9%), and has higher total costs ($156 million vs. $86 million), respectively. The objective of this study was to describe the result of the implementation of a bundle of measures for the prevention of NV-HAP in adult patients in a University Hospital in Colombia.

Methods. Descriptive study in a period of 2 years, a care bundle for the prevention of NV-HAP was implemented in adult patients of a university hospital that consisted of: (1) identification of patients at risk (patients over 60 years of age, or with altered consciousness, or swallowing disorder, or patients with tracheostomy), (2) marking the patient with a sticker on the head of the bed, and (3) implementation of the following measures: head of the bed elevation to 30°–45°, oral care every 12 hours, chlorhexidine oral rinse decontamination every 12 hours and aspiration of secretions as needed. In the first 6 months, training was carried out for all staff, the monthly adherence to the strategy was measured. Studies with a better design should be done to confirm the findings.

Disclosures. All authors: No reported disclosures.

1268. Transmissibility of Candida auris by Type of Inpatient Healthcare Facility
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Session: 139. Healthcare Epidemiology: Outbreaks
Friday, October 5, 2018: 12:30 PM

Background. Candida auris is a multidrug-resistant yeast causing outbreaks in hospital settings. Stopping the spread of C. auris is critical to the identification of healthcare facilities at risk of higher transmission to help targeted implementation of infection control measures. We used data collected during public health investigations to quantify transmissibility of C. auris by type of healthcare facility.

Methods. In two states, 3,159 patient swabs were collected during 96 C. auris point prevalence surveys conducted at 36 inpatient and long-term care facilities in November 2016.