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
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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 re-analyzed, 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.

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.

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.

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1267. Nonventilator Hospital Acquired Pneumonia (NV-HAP) Prevention Initiative in Colombia, Bogotá
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Background. Pneumonia is the second most common health-care-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 prevention of NV-HAP was implemented in an adult 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.

Conclusion. The strategy of prevention of NV-HAP decreased the cases of nosocomial pneumonia in a university hospital, through the education a high adherence to the strategy was achieved. Studies with a better design should be done to confirm the findings.

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1268. Transmissibility of Candida auris by Type of Inpatient Healthcare Facility
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Background. Candida auris is a multidrug-resistant yeast causing outbreaks in healthcare settings. Stopping the spread and 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 intensive care facilities in November 2016.