

Conclusions: This multi-disciplinary resource, particularly during periods of evolving PPE guidance and supply chain insecurity, was vital. Additionally, it expanded the pool of staff to advocate for HCW safety and IP&C principles.

All HCWs can benefit from learning about this novel model that can be adapted to any institution and various scenarios. We recently adopted this model to support staff in psychiatry with an influx of patient volumes and their needs.

Environment of Care

EC-50

Addressing Water Age to Manage Legionella Pneumophila

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Background: A Minnesota Hospital established a Water Management Program (WMP) aligned with Centers for Medicare and Medicaid Services (CMS) and American National Standards Institute/American Society of Heating, Refrigerating and Air-Conditioning Engineers (ANSI/ASHRAE) Standard 188 with the goal to mitigate the risk of waterborne pathogen disease, namely Legionella pneumophila. Initial culture-based validation testing yielded positive Legionella results at distal locations including patient rooms in the potable water systems. Water quality monitoring confirmed low levels of free residual oxidant (FRO) disinfectant, leading to higher Legionella positives. This lower FRO was identified as a problem caused by high water age, defined by a long period of stagnation of water in the potable systems. To address the water age, the hospital's water management team (WMT) implemented a flushing program as part of ongoing verification and validation protocols.

Methods: Based on industry standards, the WMT focused on achieving a minimal control limit of 0.2 ppm (parts per million) of FRO to reduce water age on hot water systems. The WMT's solution included automated flushing on hot water returns, Environmental Services (EVS) personnel provided manpower for flushing at fixtures in patient areas based on low census and patient discharge. Validation testing confirmed the efficacy of the flushing program to reduce water age which in turn reduced Legionella growth.

Results: The flushing program was able to increase the average FRO level in the hot water systems < 0.05 ppm (2019) to >0.20 ppm (2021). The higher FRO levels contributed to the downward trend of 17% positive Legionella samples (2019) to 0% (2021) during Validation sampling.

Conclusions: Reducing water age by involving EVS in the WMT and implementing flushing procedures increased FRO levels system wide. Flushing was the simplest, safest, and most cost-effective solution compared to other solutions like supplemental disinfection while also reducing positive-detect Legionella samples.

EC-51

Management of a Candida Auris Patient Across Two Healthcare Systems

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Background: Containing *Candida auris* (*C. auris*) has proven to be especially challenging during the COVID-19 pandemic given the enormous constraints on Infection Prevention (IP) departments. Knowledge of the organism, appropriate identification methods, and infection prevention strategies are key to reducing the risk of transmission. Many IP departments have been unable to develop or maintain comprehensive admission screening protocols and have limited best practices available for managing *C. auris* patients in the acute care setting. We describe the first case of *C. auris* in the acute care setting in the state of Minnesota and outline the infection prevention strategies used by the two systems that provided care to this patient.

Methods: Upon receipt of a preliminary positive *C. auris* result at Hospital One, the patient was placed into contact precautions. All patients that were identified as exposed were screened. A comprehensive infection prevention strategy was implemented in collaboration with the state health department and Hospital Two. The plan included transmission-based precautions, hand hygiene compliance, environmental cleaning and disinfection, and staff and patient education.

Results: A total of 48 patients were screened for *C. auris* at Hospital One and no additional positive results were identified. The patient was transferred to Hospital Two for progressive care needs and required an extensive hospital stay post-surgery. No additional screening was recommended by the state health department. Practical prevention strategies for high level disinfection and sterilization, environmental cleaning, patient transport and ambulation, and procedural protocols were developed. No additional *C. auris* colonization nor clinical isolates have been identified to date.

Conclusions: This case highlighted the importance of inter-facility communication and the need for an established screening protocol for *C. auris* to identify cases in a timely manner. The robust infection prevention strategies implemented by the two systems resulted in no known transmission to other patients or staff.

EC-52

When Too Much of a Good Thing Becomes Harmful: A Cluster of Aspergillosis in Premature Extremely Low Birthweight Neonates

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Background: The movement of premature Extremely Low Birthweight (ELBW) neonates imposes risk for brain hemorrhage. In response to this concern, the babies in the Neonatal Intensive Care Unit (NICU) were enrolled in the newly adopted Intraventricular Hemorrhage (IVH) Prevention Bundle, where infants were immobilized in supine position for the first seventy-two hours of life. Four neonates from the NICU were diagnosed with Primary Cutaneous Aspergillus (PCA) infection after exposure to this life-saving protocol.

Methods: An internal multi-disciplinary team was convened to investigate these four cases. The case definition included infants who were enrolled in the IVH protocol starting in 2016. A review of the NICU's environment-of-care (EOC) elements was performed. This included retrospective air-quality culture surveillance data for molds