Methods. *F. oxysporon* was grown on Sabouraud Dextrose (Sab Dex) agar. Two protocols were used: (1) aliquots of ~1 × 10^6 CFU were loaded to the surface of eight NAD's and allowed to air dry, and (2) the surface of 20 NAD's were contaminated via touching to a dense lawn of *Fusarium* on culture plates. Half of the NAD's were decontaminated with a port protector for one minute; the other half had no decontamination step (along with positive/negative controls). NAD's were then (1) placed whole in Sab Dex broth or (2) touched to a fresh Sab Dex agar plate, and growth observed for 7 days.

Results. In all cases, NAD's that had been decontaminated with the alcohol-impregnated port protector showed no growth after seven days in broth (Figure 2) or on plates (Figure 3). NAD's lacking the decontamination step invariably showed abundant growth.

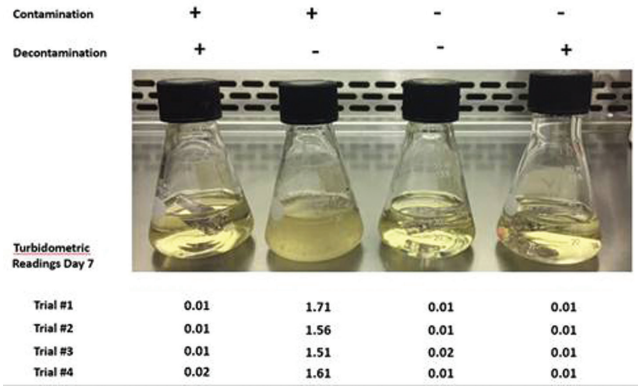

Figure 2. Growth in broth after 7 days of decontaminated (+) vs. nondecontaminated (–) NAD's, with appropriate controls

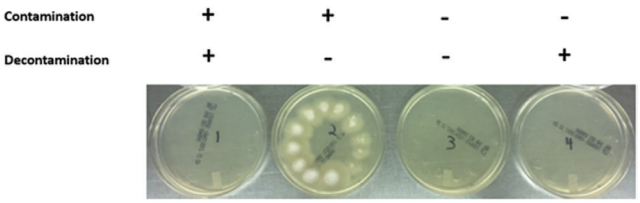

Figure 3. Growth on plates after 7 days of decontaminated (+) vs. nondecontaminated (–) NAD's, with appropriate controls. Ten replicates performed.

Conclusion. Use of two different techniques demonstrates that a 70% isopropyl alcohol impregnated port protector achieves decontamination of *F. oxysporon* from the surface of needleless access devices.

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2091. The Impact of Infection Control Cost Reimbursement Policy on Trends in Central Line-Associated Bloodstream Infections

Ki Tae Kwon, MD, PhD[1]; Won Kee Lee, Ph. D.[2]; Mi Hyae Yu, RN[3]; Hyun Ju Park, RN[3]; Kyeong Hee Lee, RN[3] and Hyun Ju Chae, RN[3]; [1]Division of Infectious Diseases, Department of Internal Medicine, School of Medicine, Kyungpook National University, Kyungpook National University Hospital, Daegu, Korea, Republic of (South), [2]Medial Research Collaboration Center, School of Medicine, Kyungpook National University, Kyungpook National University Hospital, Daegu, Korea, Republic of (South), [3]Department of Infection Control, Daegu Fatima Hospital, Daegu, Korea, Republic of (South)

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Background. In September 2016, the Korean National Health Insurance Service began reimbursing infection control (IC) costs on condition that dedicated doctors and nurses for IC should be allocated in the hospital. We assessed the Impact of IC cost reimbursement policy on trends in central line-associated bloodstream infections (CLABSI).

Methods. A before-and-after study between pre-intervention (January 2016 to February 2017) and intervention (March 2017 to December 2017) periods was performed in three intensive care units (ICU) at Daegu Fatima Hospital (a 750-bed, secondary care hospital in Daegu, Republic of Korea). The number of dedicated IC nurses increased from 2 to 5 in September 2016 and a first dedicated IC doctor was allocated in March 2017 according to the IC cost reimbursement policy. The enhanced IC team visited ICUs daily and monitor and educate the implementation of CLABSI prevention bundles. The trends between pre-intervention and intervention periods were analyzed by segmented autoregression analysis of an interrupted time series.

Results. The average CLABSI rates and total central-line days in the pre-intervention and intervention periods were 3.41 and 2.34 per 1,000 catheter-days; 7,326 and 5,978 days, respectively. Autoregressive analysis revealed that the CLABSI rates per 1,000 catheter days per month in the pre-intervention and intervention periods were -0.256 (95% confidence interval (CI), −0.593, 0.081; $P = 0.148$) and −0.602 (95% CI, −0.935, −0.268; $P = 0.008$). The rates of compliance with maximal barrier precaution significantly improved from pre-intervention (55.1%) to intervention (89.4%) period (chi-square test, $P < 0.001$). The rates of compliance with maintenance bundles also significantly improved from pre-intervention (48.4%) to intervention (69.7%) period (chi-square test, $P < 0.001$)

Conclusion. The reimbursement policy for IC cost accelerates the decline in CLABSI rates by increasing the number of IC professionals and improving monitoring, education and implementation of CLABSI prevention bundles.

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

2092. How Long Should You Delay Insertion of a Long-Term Central Venous Catheter (LTCVC) in Patients with Candida Bloodstream Infection (CBSI)?

Evgenia Kagan, MD[1]; Robert Jakubowski, MD[1]; Shruti Puri, MD[1]; Frederick Nolte, PhD, D(ABMM), F(AAM)[2] and Cassandra Salgado, MD, MS[1]; [1]Infectious Diseases, Medical University of South Carolina, Charleston, South Carolina, [2]Clinical Laboratory Services, Medical University of South Carolina, Charleston, South Carolina

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Background. Guidelines suggest that among patients with candidemia, placement of an LTCVC, often needed for treatment, can proceed when "additional blood cultures show no growth" but the timeframe is not well defined. There is theoretical risk of relapsed CBSI after therapy if yeast are still circulating in the blood and adhere to the LTCVC. We sought to determine the blood culture time to detection (TTD) for candida to identify a timeframe for LTCVC insertion that would mitigate risk for relapsed CBSI.

Methods. We conducted a retrospective cohort study of all positive (+) blood cultures for *Candida species (albicans*, *glabrata*, *tropicalis*, *parapsilosis*, *dubliniensis*, *krusei*, and *lusitaniae)* isolated from August 1, 2013–December 31, 2017. Data were retrieved from the microbiology laboratory and the BD BACTEC™ blood culture system was used. TTD was recorded for each (+) blood culture in hours and the mean TTD was calculated by species.

Results. One hundred and twenty-eight blood cultures were (+) for *Candida species. C. glabrata* was the most common species isolated, followed by *C. albicans* and *C. parapsilosis*. Overall, the mean TTD was 43 hours (range 7.1–117.7 hours); 19.5% were positive within 24 hours, 67.2% within 48 hours, and 86.7% within 72 hours, and none required more than 120 hours (table).

Conclusion. Among patients with candidemia, the majority of blood cultures were positive within 72 hours after inoculation and all were positive within 120 hours; however, among the three most common species, 16.3% required more than 72 hours. Waiting 120 hours before insertion of a LTVC should mitigate risk for relapsed CBSI

Table. TTD for Candida Species Isolated from Blood Culture

	# (%)	TTD (Hours)		# (+) Within 24 Hours (%)	# (+) Within 48 Hours (%)	# (+) Within 72 Hours (%)	# (+) Between >72–120 Hours (%)
		Mean	Median				
C. glabrata	52 (40.6)	44	33	8 (15.4)	27 (51.9)	8 (15.4)	9 (17.3)
C. albicans	27 (21.1)	48	49	3 (11.1)	10 (37)	10 (37)	4 (14.8)
C. parapsilosis	25 (19.5)	45	38	5 (20)	12 (48)	4 (16)	4 (16)
C. tropicalis	14 (10.9)	34	34	5 (35.7)	6 (42.8)	3 (21.4)	0
C. krusei	6 (4.7)	31	29	2 (33.3)	4 (66.7)	0	0
C. dubliniensis	3 (2.3)	23	19	2 (66.7)	1 (33.3)	0	0
C. lusitaniae	1 (0.8)	30	30	0	1(100)	0	0
Total	128	43	37	25 (19.5)	61 (47.7)	25 (19.5)	17 (13.3)

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2093. Chlorhexidine Gluconate Bathing to Prevent Central Line Associated Infections: What to Do When the Patient Can Bathe Themselves

Susan C. Bleasdale, MD[1,2]; Celsa Hermoso, RN, BSN[1]; Maria Grace Aguada, RN BSN PCCN[1]; Ellen J Casto, MPH[1] and Leanne O'Connell, RN, BSN, MPH[1]; [1]University of Illinois Hospital and Health Sciences System, Chicago, Illinois, [2]Division of Infectious Diseases, University of Illinois at Chicago, Chicago, Illinois

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Background. Bathing with pre-medicated 2% chlorhexidine gluconate (CHG) impregnated cloths is for prevention of central line associated blood stream infections (CLABSI). The use of CHG on patients outside of intensive care units has not been well studied. In our bone marrow and stem cell transplant unit (BMTU) we found compliance with CHG bathing to be lacking.

Methods. This was a quality improvement quasi-experimental pre-post intervention project to improve the use of CHG bathing for prevention of CLABSI in BMTU patients with central venous catheters (CVC). Review of CLABSI data identified high rates in BMTU compared with other units and significant numbers of Gram-positive organisms, suggesting needed increase in interventions directed at CVC maintenance.