**Background:** Infections caused by multi-drug resistant organisms (MDRO) are an important patient safety concern in acute care hospitals. Identification and prevention of MDRO infections remains a major component of infection control programs.

**Objective:** To describe MDRO policies and practices employed by infection preventionists (IP) in ICUs across the country and determine if their presence and implementation differ by infection control department and hospital characteristics.

**Methods:** A cross-sectional survey was performed in 441 hospitals participating in the National Healthcare Safety Network (NHSN). For each medical, medical/surgical and surgical ICU in their hospitals, IP were asked if the ICU had a written policy in place to: screen all patients for MDROs upon admission or screen periodically after admission, use presumptive isolation/contact precautions (CP) pending a culture, isolate or cohort patients with positive cultures. IP were also asked the proportion of time each policy was correctly implemented. Descriptive statistics and logistic regressions with robust standard errors were conducted.

**Results:** Data were available from 415 ICUs in 250 hospitals (response rate of 57%). A written policy to screen all patients upon admission was reported in 40% of the ICUs and 27% reported a policy to screen periodically after admission. Thirty one percent of the ICUs reported a policy requiring isolation/CP pending a screen; 98% and 43% reported a policy for CP for culture-positive patients and to cohort colonized patients, respectively. ICUs in states with mandatory reporting of HAIs were more likely to report the presence of a policy to screen all patients upon admission (OR = 2.52, p = 0.003), screen periodically (OR = 2.25, p = 0.028) and cohort colonized patients (OR = 1.91, p = 0.031). ICUs in teaching hospitals were more likely to report a policy to screen all patients (OR = 1.80, p = 0.048) and to screen periodically (OR = 2.68, p = 0.004). Presence of an electronic surveillance system was associated with having a policy to screen periodically (OR = 1.95, p = 0.05). Number of hospital beds was positively associated with having a policy for CP pending a screen (OR = 1.004, p = 0.03) but negatively associated with having a policy for isolation/CP for culture positive patients (OR = 0.998, p = 0.027). Several infection control staffing variables also predicted the proportion of time MDRO policies were correctly implemented. For example, the number of full time IP per 100 beds was positively associated with correct implementation of periodic screening all of the time or usually (OR = 1.009, p = 0.004).

**Conclusions:** This study provides a snapshot of the range of policies and practices related to MDRO in this select group of hospitals and suggests that the presence and implementation of different MDRO policies varies according to certain hospital and infection control department characteristics.

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