

<b>Author and Co-authors:</b>	Kari Gabehart, MSN, FNP; Sara Tuvell, BSN; David Roggy, RN; Natalie Fitzgerald, BSN; Rajiv Sood, MD Eskenazi Health , Richard M. Fairbanks Burn Center, Indianapolis, IN
<b>Objective:</b>	Upon completion of the lecture, attendees should be better prepared to: <ul style="list-style-type: none"><li>▪ Recognize the effort required to continue to care for patients in the event of multiple patients needing to be isolated.</li></ul>
<b>Abstract:</b>	<p><b>Introduction:</b> Fungal infections in burn patients are not uncommon related to large TBSA injuries, immunosuppression, and challenges with nutrition. In the March of 2017, our burn center experienced a trend of positive quantitative wound cultures for <i>Fusarium</i> in four different patients. Here, we share our approach to this outbreak and the changes to our practice as a result of this incidence cohort patients and do a full investigation of environmental workflow practices and process. In addition environmental cultures were obtained.</p> <p><b>Methods:</b> A multidisciplinary team to include medical leadership, nursing leadership, PT/OT, rehabilitation, EVS, quality/risk, facilities and infection control was formed to investigate. All four patients were cohorted in a closed environment on our burn unit and received 1:1 care until discharge. Through architectural design of our burn center we were able to remain open during this time to accept new patients. From March 20-April 11th the entire burn center was terminally cleaned to include all direct and indirect patient care areas. Air quality testing and surface testing was completed by an outside company to look for a <i>Fusarium</i> source. The team met daily to communicate progress and findings. All cleaning practices, infection control protocols and workflow processes were reviewed.</p> <p><b>Results:</b> All air quality and environmental surface cultures were negative for <i>Fusarium</i> and no firm source was identified. One consistent denominator was all operations were performed in the same room although on different days so energy around OR terminal cleaning and culturing was an initial focus. With a focus on wound as a primary source we evaluated our workflow practices as it related to wound cleansing, dressings, surface cleaning including beds, and overall contact of ancillary devices touching the wounds such as cables and splints. The financial impact was substantial totaling 1.3 million dollars. These charges include the room and board cost for the patient, increase in salaries paid due to the need for 1:1 care for four patients, and the environmental testing of the entire burn center. Three patients survived and one expired. All were treated systemically, topically and underwent serial debridements as necessary for source control.</p>

**Implications to Practice:** Our leadership took a proactive approach to review practices and investigate processes as a result of this infectious outbreak. A variety of processes were reviewed and changed as a result of our review. These processes include but are not limited to: enhanced terminal and daily cleaning practices of patient rooms, equipment and operating rooms, weekly leadership rounds with infection control practitioners, and increased preventative maintenance of patient rooms. This experience enhanced our awareness and allowed opportunity for us to find improvements in our daily workflow practices and cleaning strategies. Since July 2017 we have had no further cultures test positive for *Fusarium* in any source.

**Disclosure:**

Kari Gabehart – No Relevant Financial Relationships to Disclose  
Sara Tuvell – No Relevant Financial Relationships to Disclose  
David Roggy – No Relevant Financial Relationships to Disclose  
Natalie Fitzgerald – No Relevant Financial Relationships to Disclose  
Rajiv Sood – Speakers Bureau: Avita