initiated on day 5. Various surveillance investigations for viral and fungal infections are utilized at the centers. The majority of centers utilized hyperalimentation (96%) in their patients with 57% of the centers using enteral feeds in conjunction with hyperalimentation.

Conclusion: Based on the responses submitted by the PBMTTC membership, the programs employ various supportive care practices. These findings suggest a need to develop evidence based clinical practice guidelines in the care of the pediatric BMT patient.

478

A CLINICAL MICROSYSTEMS APPROACH TO REDUCE VANCOMYCIN-RESISTANT ENTEROCOCCUS (VRE) INCIDENCE IN PATIENTS TRANSPLANTED IN A PEDIATRIC ONCOLOGY & STEM CELL TRANSPLANT UNIT


The overall colonization rates of Vancomycin-resistant enterococcus (VRE) in patients with cancer and other chronic diseases are high. On an inpatient unit combining Hematopoietic Stem Cell Transplant (HSCT) patients with general hematology, oncology, nephrology and orthopedic patients the high colonization rates of VRE in these populations may be another risk factor for transmission to HSCT patients in addition to their prolonged neutropenia and multiple antimicrobial medications. VRE bacteremias during HSCT have been associated with high morbidity and mortality. During the first quarter of 2009, 4 of our transplant patients had symptomatically positive VRE stool cultures and 1 also had VRE bacteremia. One of these patients had sickle cell disease and had no history of prolonged use of antibiotics prior to his positive VRE stool culture. All patients tested positive for the same VRE strain, which was also identified in a non-transplant patient hospitalized on the same inpatient unit. Therefore, a multidisciplinary (Microsystems) team was established within our department to implement and monitor the recommended infection prevention measures put forth by the Center for Disease Control (CDC) and Joint Commission. The multidisciplinary team was comprised of staff from the inpatient and outpatient units, infection control, environmental services and administration. The areas of focus included judicious use of antibiotics, education of staff, patients and families regarding hand hygiene compliance, standard and contact precautions recommendations and adherence, and surveillance for VRE. Patient and family surveys were conducted to identify the possible causes of VRE transmission and educational needs of staff, patients and families. A “VRE+” sticker was placed on the cover of the patient’s medical chart and VRE positive status was communicated to all ancillary care services. Our team met bi-weekly to update the process. Through these interventions and the reinforcement of the VRE policy, we are pleased to report there have been no new patients with VRE infection in the second and third quarter of the year for our inpatient and outpatient Hematology and Oncology Units.