Table 1. Median time-to central line removal/replacement (in hours) by condition of placement

	Non-sterile	Sterile	P-value
All patients (n = 284)	56.3 (26.5, 155.7)	90.7 (41.2, 150.2)	**0.038**
Excluding those who died (n = 199)	89.8 (44.2, 168.5)	90.7 (48.6, 145.8)	0.775

Note: Data are median (interquartile range)

prevention measures and highlight the need for multidisciplinary strategies to support timely replacement of emergently placed central lines.

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Poster Presentation
Subject Category: CLABSI
Device Stewardship: Opportunities and Experience with Early Efforts‡

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Background: Vascular access devices (VAD), including central venous catheters (CVC) and peripheral intravenous catheters (PIVC), are among the most common medical intervention for hospitalized patients, yet they are also a major source of infectious and noninfectious complications. The Centers for Disease Control and Prevention (CDC) recommends prompt removal of CVC that are no longer indicated as a cornerstone of CLABSI prevention, although cessation of CVC indication is ill-defined. Our hospital implemented a Device Stewardship program to identify VAD that were likely inappropriate and to nudge providers to remove them promptly. The objective of this study is to quantify the opportunities to decrease VAD utilization and to describe early Device Stewardship efforts. Methods Study design and population. This is a retrospective cohort study at a 500-bed academic safety net hospital in Denver, CO. All inpatients hospitalized between 10/1/2025 and 12/31/2025, were eligible for inclusion. CVC placed for ECMO or rapid rewarming were excluded. Definitions. The following VAD were generally considered unnecessary: Femoral triple lumen catheters (TLC) in place for <1 day TLC present in a patient on an acute care unit Duplicate VAD (peripherally-inserted central catheter [PICC] and PIVC) in a patient on an acute care unit Intervention. Infection preventionists (IPs) identified eligible patients through an Epic worklist. Standardized text messages were used to suggest de-escalation of VAD to nursing and provider teams on weekdays (Figure 1). Results There were 576 TLC device days and 871 PICC device days in hospitalized inpatients during the study period. VAD selection could be improved in 29.6% of these patients (Table 1). Duplicate VAD was identified as the most frequent opportunity for improvement whereas femoral TLC present for <1 day was the least frequent opportunity. IPs contacted the clinical teams of 64 unique patients with duplicate VAD to suggest

Figure 1. Standard text used by infection preventionists to suggest de-escalation of vascular access devices to nursing and provider teams.

Femoral central venous catheters in place for >1 calendar day Hi, I work with Infection Prevention. As part of our Device Stewardship initiatives, we are reaching out to teams of patients with femoral lines in >24 hours because they are at highest risk for infection. We'd like to determine if there is a continued need to use that line or if alternative (i.e. with fewer lumens, different site, etc.) lines may be appropriate. To decrease the risk of infection to the patient, we would recommend moving the line to another location such as IJ or subclavian. Thank you for your review!
Triple lumen catheters on acute care units I work with Infection Prevention. As part of our device stewardship initiatives, we are reaching out to teams of patients with central lines because they are at higher risk for infection. We'd like to determine if there is a continued need to use that line or if alternative (i.e. with fewer lumens, different site, etc.) lines may be appropriate. Do you know why this pt still has their *triple lumen CVC/double lumen CVC*? Thank you for your review!
Duplicate vascular access devices: peripherally-inserted central catheter plus peripheral intravenous catheter on acute care units Good morning ~ I work with Infection Prevention and am reaching out because of our device stewardship initiative to reduce PIV-related bacteremia. We are looking at patients with both PICCs and PIVs and want to check in with the care team to see if it would be possible to remove the PIV. Does the patient have an ongoing need for the PICC plus the PIV, or would the PICC be sufficient? Thank you for your review!

Table 1. Quantity of opportunity for Device Stewardship interventions, Oct 1-Dec 31 2025

Variable	Device days
Total triple lumen catheter and peripherally-inserted central catheter device days	1447
Triple lumen catheter device days	576
Femoral triple lumen catheter device days	29
Peripherally-inserted central catheter device days	871
Peripherally-inserted central catheter device days on acute care	352
Opportunity #1: Femoral triple lumen catheter device days present >1 calendar day	13
Opportunity #2: Triple lumen catheter device days on acute care	63
Opportunity #3: Peripherally-inserted central catheter device days on acute care with concurrent peripheral intravenous catheter	352
Total opportunities: Device days	428

removal of ≥1 PIVC; 36 PIVC in 25 patients (39%) were removed as a result of intervention. Additionally, 5 femoral TLC present for <1 day and 15 TLC on acute care units were intervened upon with 1 femoral line and 3 TLC (20% each) removed during the study period. Conclusion Despite national guidelines to remove unnecessary VAD, there is ample opportunity to deescalate VAD in clinical practice. Simple criteria can be developed to standardize the selection and to prompt earlier removal of VAD, particularly duplicate access. Work can be done to improve the acceptance rate of suggestions.

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Impact of Plasma Next Generation Sequencing (pNGS) on CLABSI Rates‡

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Background: PNGS technology to identify microbial DNA in blood, is used to diagnose infections not identified with standard cultures. The National Healthcare Safety Network (NHSN) defines central line associated bloodstream infection (CLABSI) as an NHSN defined laboratory confirmed bloodstream infection (LCBI) in the presence of an eligible central line. The LCBI definition was updated in 2020, to include pNGS as a non microbiologic test to define CLABSI, not accompanied by a standard blood culture. This study describes the adverse impact of pNGS on CLABSI rates at a pediatric hospital. **Methods:** CLABSI events attributed to pNGS results, were identified through hospital infection control records from January 2020 through June 2025. Medical charts were reviewed for blood cultures, indications for testing, prior pNGS, and changes in antimicrobial therapy based on pNGS results. CLABSIs associated with mucosal barrier injury (MBI) were not included as these are not part of nationally reported rates. **Results:** 138 eight CLABSI events were identified during this timeframe, with 21(15.2%) defined by pNGS results. CLABSI rates are shown in the Table. Of pNGS defined CLABSI events, 11 patients had sites of infection other than blood, and 6 had pNGS done only to follow up prior pNGS results. Eight children with organisms identified on pNGS were already being treated and 8 new organisms on pNGS results were considered not clinically significant and not treated. Antimicrobial therapy was given in response to pNGS results for 5 patients: a neonate with candida and ureaplasma on pNGS, a pancreatitis patient with Enterococcus avium and Staphylococcus epidermidis on pNGS, a patient started on ganciclovir due to CMV, and 2 patients treated for organisms on pNGS associated with

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