

became available, CSF culture positivity for *C. acnes* returned to baseline (late November or early December) (Fig. 1). **Conclusions:** We identified a likely pseudo-outbreak related to temporary use of a more sensitive culture media. No direct patient harm was identified, although many had increased risk of harm by surgical intervention or prolonged length of stay. Technological advances may enhance organism identification but challenge existing paradigms of care. More studies are needed to better delineate the intersection of diagnostic advancements with patient care standards.

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Investigating a cluster of pediatric oncology invasive fungal infections—Lessons learned

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Background: In spring 2021, the infection prevention and control department at a pediatric academic medical center identified 3 oncology patients with concern for invasive *Rhizopus* spp infections. An in-depth investigation was conducted, but a common source of the fungus was not identified. In August 2021, an additional oncology patient with concern for invasive *Rhizopus* spp was identified, resulting in an extended investigation for possible sources of fungus. **Methods:** A multidisciplinary work group was assembled. The CDC Targeted Environmental Investigation Checklist for Outbreaks of Invasive Infections Caused by Environmental Fungi was used as a framework for conducting the investigation. Stakeholders were engaged throughout the process, including the hematology–oncology service, hospital leadership, environmental services, patient safety and quality, and facilities and engineering. The investigation included hospital incident command system (HICS) activation; visual inspection of patient rooms and common spaces; heating, ventilation, and air conditioning (HVAC) review; environmental sampling (surfaces, linen, and air); chart review; and process mapping. **Results:** By early October 2021, 2 environmental samples grew isolates (each at 1 CFU/m³) of the same species of *Rhizopus* as one of the affected patients. One sample was from a patient room, and the other from an outdoor garden space. No source of indoor amplification of *Rhizopus* was identified. The investigation revealed several opportunities for improvement: annual room maintenance schedules, use of gardens and outdoor spaces by at-risk patients, linen storage, construction and/or infection control risk assessment (ICRA) processes, and appliances used by families (eg, washing machines and refrigerators). Work streams were established to address each of these areas. **Conclusions:** No definite source was identified for the 4 invasive *Rhizopus* spp infections. This extensive investigation highlighted multiple opportunities for improvement; the changes implemented may prevent future invasive fungal infections in high-risk pediatric patients.

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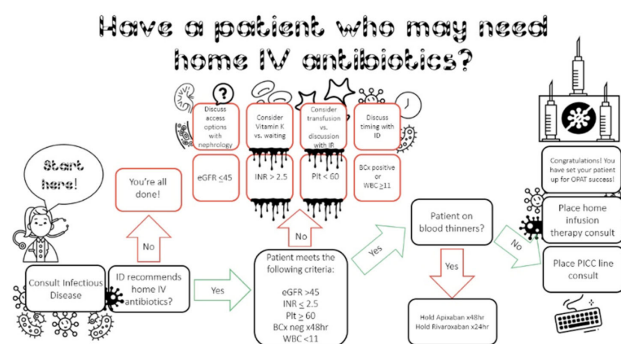
My patient needs home IV antibiotics—Now what? Assessing OPAT involvement at a Veterans' Affairs hospital

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Background: Outpatient parenteral antimicrobial therapy (OPAT) involves the administration of intravenous antimicrobial therapy outside

the hospital. The literature suggests that inpatient providers are often unaware of OPAT programs and may not engage this multidisciplinary group in a timely fashion, leading to potentially inappropriate OPAT use. However, few studies have directly addressed this issue. We characterized current practices for coordinating OPAT and assessed provider understanding of OPAT services. We also conducted an exploratory analysis of placement of a peripherally inserted central catheter (PICC) consultation prior to an infectious disease (ID) consultation as a proxy for potentially avoidable OPAT use. **Methods:** This study was conducted between September and December 2021 at the Ann Arbor VA Healthcare System. All charts (n = 212) in which a consultation for a PICC was placed between January and September 2021 were reviewed, including free-text data entered by patient teams and inpatient progress notes in the days leading up to and following PICC consultation. Additionally, inpatient providers were surveyed using an online format regarding knowledge, utilization, and perceptions of OPAT. **Results:** Of the 212 charts reviewed, 108 patient encounters resulted in PICC placement; 80 (74.1%) were placed for the indication of home IV antibiotics. Of these, 3 (4.0%) had the PICC consult placed prior to the ID consultation. Of the 104 PICC consultations that were cancelled, 9 (8.7%) were cancelled because the ID staff did not recommend home IV antibiotics. Other reasons for cancellation included alternative device placement, duplicate order, referral to interventional radiology, failure to meet criteria, or unsuccessful placement. Of the 285 inpatient providers sent the electronic survey, 121 (46.9%) completed at least some portion. Overall, 17 respondents (14.0%) were familiar with the acronym OPAT; however, only 10 were able to expand the acronym correctly. Of the 118 respondents asked about their familiarity with the OPAT program at the local institution, 98 (83.1%) were not familiar at all or were only slightly familiar with the program. In contrast, 7 respondents (6.0%) were very or extremely familiar with the OPAT program. **Conclusions:** Further education and structural interventions are necessary to improve inpatient providers' awareness and early engagement of local OPAT programs to ensure appropriate OPAT use. An educational intervention with an informative flowchart diagramming the steps for engaging the OPAT team could raise

Figure A: Workflow of Outpatient Parenteral Antimicrobial Therapy at the Ann Arbor VA Healthcare System



What is OPAT?

Outpatient Parenteral Antimicrobial Therapy (OPAT) involves the administration of parenteral (intravenous) antimicrobial therapy without an overnight hospital stay. Patients are frequently transitioned to OPAT following an inpatient hospitalization.

Is there an OPAT program at the Ann Arbor VA?

The Ann Arbor Veterans Affairs Hospital has a multidisciplinary OPAT program, consisting of Infectious Disease (ID) physicians, ID pharmacists, ID nursing, vascular access nursing, social workers, and community care workers, that works to provide appropriate monitoring and follow up for Veterans discharged from inpatient hospitalizations with IV antibiotic therapy. This team is crucial to ensure safety and appropriate follow up in the outpatient setting!