

Hospital	Number of hospital acquired infections caused by <i>Stenotrophomonas maltophilia</i>	Percentage of all nosocomial infection microorganisms	Total of patients admitted at each hospital	Incidence rate of HAI caused by <i>Stenotrophomonas maltophilia</i> (#HAIs per 10.000 hospital admissions)
I	2	0.2%	53,284	0.4
II	12	1.0%	89,552	1.3
III	45	1.2%	161,721	2.8
IV	0	0.0%	74,367	0.0
V	0	0.0%	116,551	0.0
VI	7	0.4%	46,627	1.5
VII	0	0.0%	56,984	0.0
VIII	15	1.0%	80,220	1.9
IX	4	0.7%	28,380	1.4
X	8	0.3%	76,843	1.0
Total	93	0.5%	784,529	1.2

Fig. 1.

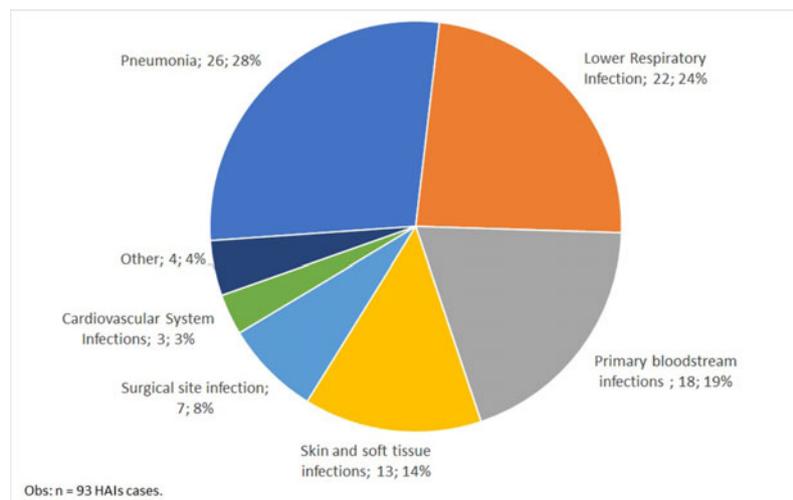


Fig. 2.

urinary tract infection, 2 (2%); gastrointestinal infection, 1 (1%); and eye, nose, throat, and mouth infections, 1 (1%). **Conclusions:** *Stenotrophomonas maltophilia* infection is a rare and highly lethal event that usually occurs after 2 weeks of hospitalization. The most affected region is the respiratory tract, with a higher incidence in patients aged >60 years or in the ICU. Early and accurate investigations of multiresistant microorganisms in a hospital setting are needed to reduce patient morbidity and mortality.

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Presentation Type:

Poster Presentation

Hospital Outbreak of Respiratory Syncytial Virus in Neonatal Intensive Care Unit: The Risk of Admitting External Patients

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Background: Acute viral bronchiolitis caused by respiratory syncytial virus (RSV) may be a manifestation of high severity in neonatal-ICU (NICU) patients, with high risk of in-hospital cross transmission and outbreaks. During the epidemic seasonal period, intense viral circulation occurs in community; thus, transmission in the NICU is difficult to control. **Objective:** We describe an

outbreak that occurred in a NICU in a public hospital in São Paulo state, Brazil. We also discuss the role of admitting external newborns with community-acquired virus in the incidence of these outbreaks in the NICU. **Methods:** In 2017 in Campinas, an RSV epidemic occurred during the seasonal period, resulting in a outbreak at the Campinas maternity hospital. A retrospective investigation was performed, and patients were analyzed for clinical and epidemiological characteristics and for risk factors for poor prognosis. We included neonates admitted in NICU with positive nasal lavage for RSV from April to July 2017. Statistical analysis were performed with χ^2 test for the categorical variables and the Student *t* test for the continuous variables comparing the newborn group from the community (external) with infected newborns in the hospital (internal). $P < .05$ was considered significant. **Results:** Of 44 neonates with RSV during this period, 32 were external and 12 were internal (Fig. 1). The mean gestational age of the external neonates was 38 weeks and 2 days, whereas the mean gestational age of the internal neonates was 29 weeks and 1 day ($P < .001$). The hospitalization time was higher in the internal group ($P < .001$). Table 1. One death associated with infection occurred in the internal group. Community neonates (external group) were mostly term-born, with no comorbidities, and they had a more favorable clinical course. In the literature, neonates infected with RSV at the hospital have several risk factors for poor prognosis, with a 13.5% mortality rate. **Discussion:** RSV outbreaks have great relevance in hospital settings, especially in the NICU, where there are a large number of vulnerable patients and a high

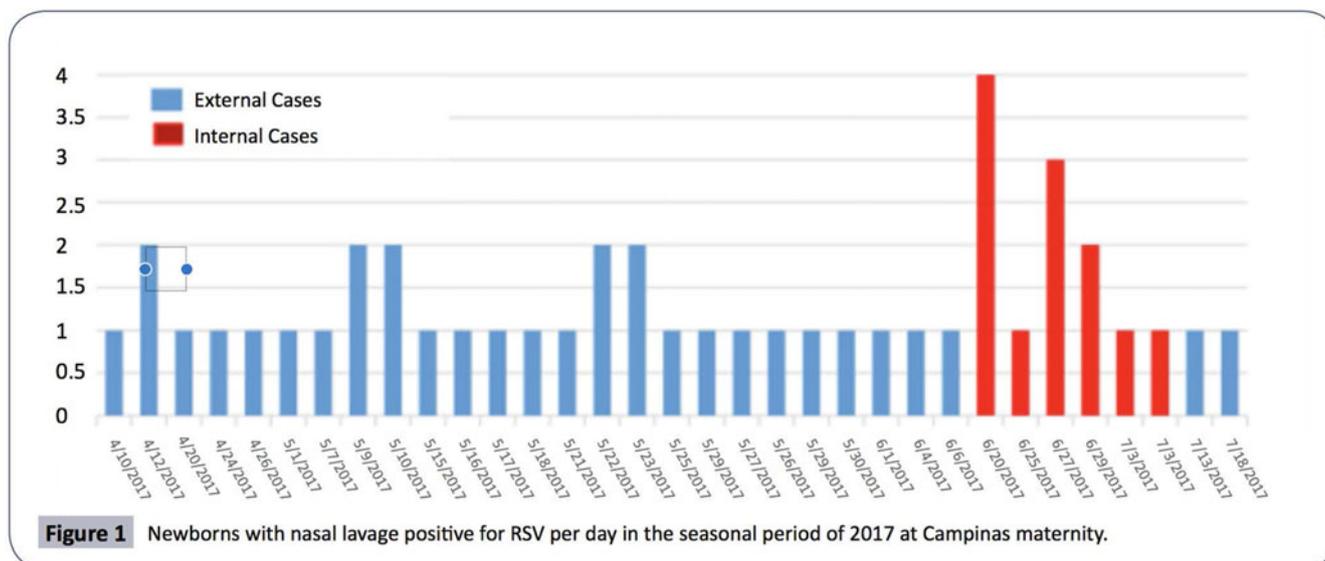


Fig. 1.

Table 2 Clinical comparison between internal and external NB, infected by RSV during the outbreak at Campinas Maternity, 2017.

Features	NB external% (N)	NB internal% (N)	p
Premature (<37 weeks)	13.3% (4)	91.6% (11)	< 0.001
Comorbidities	3.13% (1)	100% (12)	< 0.001
Upper Respiratory Symptoms	93.75% (30)	8.3% (1)	<0.001
Low Respiratory Symptoms	62.5% (20)	75% (9)	0.29
Mechanical Ventilation (VM)	37.50% (12)	58.33% (7)	0.18
Asymptomatic	0	25% (3)	0.03
Length of hospitalization days - Mean (change)	11.3 (3-49)	81.4 (21-150)	<0.001
Time of VM days Mean (range)	1.9 (0-8)	17.2 (11-59)	<0.001

Fig. 2.

risk of in-hospital cross transmission. Neonates infected with RSV at the hospital have several risk factors for poor prognosis, including high mortality. Therefore, it is important to discuss the exposure of this population to community-based infectious agents, mainly viral, and the risk of accepting patients from the community to be admitted to the NICU.

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Hospital Policies Related to Transmission of Methicillin-Resistant *Staphylococcus aureus* (MRSA)

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Background: MRSA continues to spread in hospitals, despite modest recent success. Gaps exist regarding how hospital policies impact MRSA transmission in hospitals. Characterization of the policy environment has been useful in approaching other public health issues including control of alcohol, firearms, tobacco, and traffic safety.

Objective: Our goal was to describe measurable and modifiable policy components designed to prevent MRSA in hospital settings. **Methods:** We examined 4 types of hospital policies from 5 metropolitan hospitals in Minnesota: hand hygiene, multidrug-resistant organism (MDRO)

and isolation, healthcare personnel influenza vaccination, and whistleblower (corporate compliance). We developed a tool to systematically evaluate policies for each topic that included 19–23 instructional and implementation elements guided by regulatory and clinical practice guidelines: purpose, expectations, education and training, monitoring, enforcement, corrective actions, responsibilities, and corrective actions. Each policy element was evaluated for its presence (yes or no) and thoroughness (nonexistent = 0, cursory = 1, thorough = 2). **Results:** All hospitals had hand hygiene and MDRO and isolation policies; 3 of 5 had influenza and whistleblower policies. The policies varied in comprehensiveness and thoroughness across hospitals and topics. Most policies included purpose and policy statements with a statement of organizational rules (14 of 16 and 16 of 16, respectively) with mean thoroughness scores of 1.04 and 1.20, respectively. Most policies lacked consequences for noncompliance (6 of 16), accountability (6 of 16), and monitoring and enforcement of policy expectations (5 of 16). When included, the policy components scored low for thoroughness, and 50% of policies (8 of 16; range, 20% for hand hygiene and 100% for influenza vaccination) specified expectations for educating staff about the policy topic, with a mean thoroughness score of 0.75. Responsibilities for policy expectations were lacking: responsibilities for product needs and availability (3 of 13), training and education (1 of 16); and monitoring compliance with skills and techniques (4 of 16). Of the 4 policy types, influenza vaccination was the most complete. All influenza policies had $\geq 50\%$ of categories completed versus hand hygiene (26%), MDRO (17%), and whistleblower (26%). The hand hygiene policies scored highest for thoroughness; 48% of policy