

the study institution was conducted at a 790-bed tertiary-care medical center in Tokyo, Japan. The ratio of the respective patients was 1:3. Factors associated with ER discharge after a blood-culture collection were identified using multivariate logistic regression analysis. **Results:** From January 2014 through December 2020, 153,432 patients visited the ER. Blood cultures were obtained for 19,010 patients; 2,575 (13.5%) of these had a true BSI, and of the latter, 142 (5.5%) were initially discharged from the ER. During 2020, the proportion of patients with ER discharge increased 1.7 times over previous years. There was no significant difference in 28-day mortality between the groups (2.1% vs 4.5%; $P = .31$). On multivariate logistic regression analysis, factors significantly associated with the decision to discharge after blood culture collection were the absence of hypotension (aOR, 14.92; 95% CI, 3.38–65.93), lack of altered mental status (aOR, 8.44; 95% CI, 3.28–21.71) at ER presentation, unknown diagnosis at ER discharge (aOR, 3.75; 95% CI, 1.97–7.16), high level C-reactive protein (aOR, 0.91; 95% CI, 0.87–0.94), and a diagnosis of intra-abdominal or hepatobiliary infection (aOR, 0.11; 95% CI, 0.04–0.29). **Conclusions:** ER discharge after drawing blood for a culture was more frequently seen in the current COVID-19 era and was deemed acceptable under certain circumstances, such as patients with no systemic illnesses or specific diagnosis who may be managed safely without compromising clinical outcomes.

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Poster Presentation - Top Poster Award

Subject Category: Pediatrics

A qualitative study of parent and childcare leadership perspectives on attendance policies at childcare centers

Nicole Poole; Brooke Dorsey-Holliman; Leisha Anderson; Sean O'Leary and Chloe Glaros

Background: Attendance policies for common pediatric illnesses vary widely across childcare centers despite nationally published guidelines from the American Academy of Pediatrics. The COVID-19 pandemic has exacerbated this problem, leading to economic loss from parental work absenteeism and excess medicalization of children with common illnesses. We sought to understand barriers to and recommendations for adopting best practices on attendance policies at Early Head Start and Head Start (EHS/HS) childcare centers. **Methods:** We conducted 19 semistructured qualitative interviews: 9 with childcare leadership and 10 with parents from EHS/HS childcare centers across Colorado. Interviews took place between April and December 2021. Interviews were audio-recorded, transcribed, and coded in ATLAS.ti using a priori and emergent coding strategies. Descriptive content analysis was used to identify central themes, which were iteratively revised by 2 authors. **Results:** We derived 7 convergent and 4 divergent themes from leadership and parents addressing attendance decisions. Overlapping themes on barriers to adopting best practices included difficulty assessing symptom severity, limited medical provider understanding of childcare requirements, parent employment pressures, and the impact of the COVID-19 pandemic on exclusion durations. Leadership and parent perspectives differed on resources utilized, understanding of exclusionary symptoms, and role of medical providers in making attendance decisions. Overlapping themes on recommendations for best practices included access to registered nursing, concrete guidance on symptoms, and partnering with health departments. Leadership and parents agree that the COVID-19 pandemic led to increased guideline use in making attendance decisions and increased rates of excluding children from class for minor illness compared to prepandemic times. Both leadership and parents recommended consistency in exclusion practices, but leadership and parents identified medical providers and childcare leadership, respectively, as current sources of inconsistency. Salient findings showed variability in defining a fever by age from both leadership and

parents. **Conclusions:** Coordination is needed between childcare centers, medical facilities, and health departments to improve attendance decisions for common pediatric illnesses. Future work should (1) develop concrete symptom guidance for parents with specific exclusion criteria (eg, via a decision aid), (2) assess the utility and feasibility of regular classroom access to registered nursing, and (3) advocate for employee protections to care for sick children at home.

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Outbreak response activities conducted by public health programs in healthcare facilities nationwide, August 2019–July 2020

Nijika Shrivastwa; Lucas Ochoa; Maroya Walters; Kiran Perkins; Joseph Perz and Jennifer C. Hunter

Background: Rapid response is critical to control healthcare-associated infection (HAI) and antibiotic resistance threats within healthcare facilities to prevent illness among patients, residents, and healthcare personnel. Through this analysis, we aimed to quantify public health response activities, by healthcare setting type, for (1) novel and targeted multidrug-resistant organisms or mechanisms (MDROs), (2) SARS-CoV-2, and (3) other possible outbreaks. **Method:** We reviewed response activity data submitted by US state, territorial, and local health department HAI/AR programs to the CDC as part of funding requirements. We performed descriptive analyses of response activities conducted during the funding reporting period (August 2019–July 2020). SARS-CoV-2 response activities were reported from January through July 2020. Data were analyzed by response category (novel or targeted MDRO, SARS-CoV-2, other HAI/AR responses), and healthcare setting type. **Results:** During August 2019–July 2020, 57 HAI/AR Programs (50 state, 1 territorial, 5 local health departments, and District of Columbia) reported 18,306 public health responses involving healthcare facilities. These data included 3,860 responses to 1 or more cases of novel or targeted MDROs, 13,992 responses to SARS-CoV-2 outbreaks (beginning in January 2020), and 454 responses to other possible outbreaks. Novel and targeted MDRO responses most frequently occurred in acute-care hospitals (ACHs, 64.5%), skilled nursing facilities (SNFs, 24.5%), and long-term acute-care hospitals (LTACHs, 5.8%). SARS-CoV-2 responses most frequently occurred in SNFs (55%), and assisted living facilities (24%). Other HAI/AR responses most frequently occurred in ACH (50%), SNF (28.4%), and outpatient settings (19.6%). Of the “other” HAI/AR responses, 76% were responses to cases, clusters, or outbreaks, and 23.8% were responses to serious infection control breaches including device and instrument reprocessing, injection safety, and other deficient practices. **Conclusions:** During the study period, public health programs performed a high volume of HAI/AR response activities largely focused on SARS-CoV-2 in nursing homes and assisted living facilities. Other important response activities occurred across a range of other healthcare settings, including responses to novel and targeted MDROs, HAI outbreaks, and serious infection control breaches. Whereas SARS-CoV-2 response activities largely centered in long-term care settings, MDRO and other HAI/AR responses occurred mostly in acute-care settings. These data demonstrate the importance of building and sustaining public health response capacity for a broad array of healthcare settings, pathogens, and patient populations to meet the range of current and emerging HAI/AR threats.

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