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1239. Frequently Identified Infection Control Gaps in Outpatient Hemodialysis Centers

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Background. Little is known about infection control (IC) practice gaps in outpatient hemodialysis centers (OHDC). Hence, we examined the frequency of IC gaps and the factors associated with them.

Methods. The Nebraska (NE) Infection Control Assessment and Promotion Program (ICAP) in collaboration with NE Department of Health and Human Services conducted on-site visits to assess infection prevention and control programs (IPCP) in 15 OHDC between June 2016 and March 2018. The CDC Infection Prevention and Control Assessment Tool for Hemodialysis Facilities was used for IPCP evaluation. A total of 124 questions, 76 of which represented best practice recommendations (BPR) were analyzed in 10 IC domains. Gap frequencies were calculated for each BPR. Fisher's exact test was used to study the association of the identified gaps with typical patient census of the facilities and chain affiliation (CA).

Results. Of the 15 OHDC, seven were large centers (typically following >50 patients) and 11 were part of national chains. Important IC gaps exist in all OHDC. A median of 64 (range 57–70) of 76 BPR were being followed by OHDC or were nonapplicable to them. The IC Program and Infrastructure domain had the highest frequency of IC gaps (Figure 1). Figure 2 describes the top 5 IC gaps. Smaller OHDC (sOHDC) and those without CA performed better in a few areas. For example, a higher proportion of sOHDC had work exclusion policies that encourage reporting of illness without any penalty when compared with larger OHDC (75% vs. 0, $P = 0.01$). Similarly, a higher proportion of sOHDC provided space and encouraged persons with symptoms of respiratory infection to sit as far away from others as possible in nonclinical areas (63% vs. 0, $P < 0.05$). None of the nonchain OHDC had shared computer charging terminals when compared with 64% of OHDC with CA ($P = 0.08$) and a majority of nonchain OHDC provided space and encouraged persons to maintain distance with others when having respiratory symptoms as opposed to a minority of OHDC with CA (75% vs. 18%, 0.08).

Conclusion. Important IC gaps exist in OHDC and require mitigation. Informing OHDC of existing IC gaps may help in BPR implementation. Larger scale studies should focus on identifying factors promoting certain BPR implementation in smaller and nonchain OHDC.

Figure 1. Frequency of Infection Control gaps within Individual Infection Control Domains

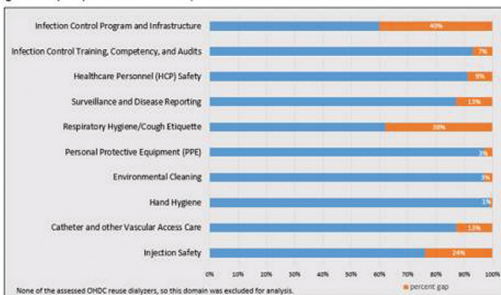


Figure 2. Most Frequently Identified Infection Control Gaps in Outpatient Hemodialysis Centers

Best Practice Recommendations	Gap Frequencies (N=15)
Dialysis center has signs posted that encourage patients to take an active role in and express their concerns about facility infection control practices	93%
Routine application of antibiotic ointment or povidone-iodine ointment to catheter exit sites during dressing changes is performed at the facility	67%
Facility provides space and encourages persons with symptoms of respiratory infection to sit as far away from others as possible, in non-clinical areas	67%
Facility has the ability to separate symptomatic patients (by at least 6 feet) from other patients and their stations during dialysis treatment?	67%
Facility has work-exclusion policies that encourage reporting of illnesses and do not penalize	60%

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1240. Antibiotic Prescribing in US Nursing Homes Using National Pharmacy Transaction Data

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Background. Antibiotics are frequently prescribed inappropriately in nursing homes (NHs); however, national estimates of NH antibiotic use are limited. We aimed to describe antibiotic prescribing in US NHs to identify potential targets for antibiotic stewardship.

Methods. A descriptive analysis was conducted using the 2014 proprietary IQVIA long-term care (LTC) Xponent database, which captures oral and intravenous antibiotic prescription transactions from sampled LTC pharmacies representing 70–85% of the LTC market. The data are projected to 100% of the US LTC market. Denominators for rate calculations were captured from the 2014 Minimum Data Set as the number of residents with at least one resident day in an NH in 2014. Antibiotic transaction counts and rates were calculated by resident gender, age, US census region, route of administration, antibiotic class and agent, and total transaction counts were summarized by provider type. Prescribing patterns for antibiotic classes and agents stratified by resident age were also calculated.

Results. In 2014, there were over 14 million antibiotic transactions in LTC pharmacies, for a rate of 3,302 per 1,000 residents. Female residents accounted for 62% of antibiotic transactions at a rate of 3,305 transactions per 1,000 residents compared with 3,240 per 1,000 male residents. Antibiotic prescribing was highest in the South at 3,752 transactions per 1,000 residents (vs. 2,601 per 1,000 residents in the West). Oral antibiotics accounted for 85% of transactions. Fluoroquinolones were the most frequently prescribed antibiotic class (22%; 723 transactions per 1,000 residents) and the most common agents were levofloxacin, ciprofloxacin, and sulfamethoxazole–trimethoprim. Stratified by age, the percent change in prescribing rates among residents aged <85 to residents aged ≥85 was largest for fluoroquinolones (645 vs. 883) and urinary anti-infectives (210 vs. 319). Internal medicine and family practice providers accounted for 37% and 32% of all antibiotic transactions, respectively.

Conclusion. A potential antibiotic stewardship target in NHs is fluoroquinolone prescribing. Targeting states in the South for interventions may have the largest impact.

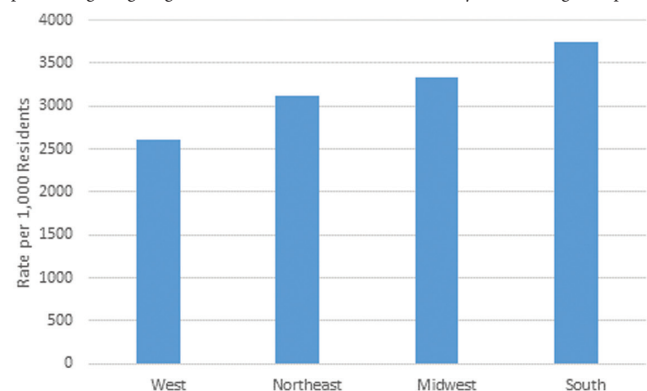


Figure. Antibiotic prescribing rates in long-term care by U.S. census regions

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1241. Surveillance for Viral Respiratory Infections in Pediatric Chronic Care Facilities

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Background. Residents of pediatric chronic care facilities (PCCFs) are vulnerable to acute respiratory infections (ARIs) due to their underlying medical conditions and infection control challenges in congregate living.

Methods. We conducted active, prospective surveillance for ARIs (defined as ≥2 new signs/symptoms of respiratory illness) among all residents in three PCCFs near New York City from December 7, 2016 to May 7, 2017. The parents/guardians of some residents also provided consent for research specimen collection at the start of the study. In that subset, nasopharyngeal swabs were obtained ≤4 days of ARI symptom