

Conclusion. Initial improvements in HH adherence preceding the start of the COVID-19 pandemic were not sustained, possibly due to increasing comfort and reduced anxiety associated with providing care to COVID-19 patients leading to a perception of reduced COVID-19 transmission risk. These findings highlight the need for HH monitoring to be tied to longitudinal unit-led quality improvement in order to achieve durable changes in practice.

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423. Implementation of a Hierarchy of Controls in a Mobile Health Unit to Safely Care for Inpatients with COVID-19 during Healthcare System Surge

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Session: P-19. COVID-19 Infection Prevention

Background. In April 2021, Sunnybrook Health Sciences Centre opened a Mobile Health Unit (MHU, i.e. medical tents) under the direction of the Ontario Ministry of Health and Long Term Care in response to a surge in hospitalized patients with COVID-19 during wave three of the pandemic. Providing care to patients in non-conventional spaces is not new, however, experience in safely caring for COVID-19 patients in these settings is lacking. Our aim is to describe the implementation of our MHU and associated outcomes of these COVID-19 patients.

Methods. A multidisciplinary clinical and operations team was created to plan, execute and operate a safe environment for COVID-19 patients and healthcare workers within the MHU. Patient selection was restricted to patients with COVID-19 who were clinically recovering from severe COVID-19 pneumonia. Ventilation was optimized with air flow directed away from patient areas, velocity reduced to below 0.25 meters per second, and air exchanges of 24-28 per hour. All healthcare workers working in the MHU were offered COVID-19 vaccine and required to complete mandatory education if they declined (vaccination rate of 87% was achieved among dedicated staff). Universal masking and eye protection was used throughout the MHU with designated areas for donning and doffing personal protective equipment.

Results. In total, 32 patients with COVID-19 were managed in the MHU between 26 April and 21 May, 2021. Table 1 provides the summary of patient characteristics. All patients had a median of one-day of transmission-based precautions remaining in their course and were infected with Alpha variant with exception of one patient with the Gamma variant. Among those patients with genotyping available, all were infected with SARS-CoV-2 carrying the N501Y mutation. Four of the 32 patients required transfer to the main hospital for medical indication while the others were discharged home or to rehabilitation. None of the healthcare workers who worked within the MHU developed COVID-19 infection.

Table 1. Patient characteristics of inpatients with COVID-19 transferred to the Mobile Health Unit (MHU).

Baseline characteristics	N=32
Age in years, median (IQR)	62.5 (16.8)
Sex, n (%)	
Female	15 (46.9)
Male	17 (53.1)
Signs on MHU admission, n (%)	
Fever (Temperature > 38°C)	4 (12.5)
Sore throat	1 (3.1)
Cough	10 (31.3)
Shortness of breath	17 (53.1)
Diarrhea	1 (3.1)
Gastrointestinal symptoms	1 (3.1)
Received 1st dose of COVID-19 vaccine, n (%)	4 (12.5)
Type of COVID-19 variant, n (%)	
N501Y	29 (90.6)
E484K	1 (3.1)
Days of COVID-19 infection on transfer to MHU, median (IQR)	18.5 (12.5)
Required additional precaution on MHU admission, n (%)	27 (84.4)
Duration of precaution, days, median (IQR)	1 (1)
Length of stay in MHU, days, median (IQR)	3.5 (4.3)
Discharge destination, n (%)	
Home	14 (43.8)
Rehabilitation or hospital once capacity available*	14 (43.8)
Transferred to main hospital for medical indication	4 (12.5)

Note: IQR, interquartile range. *5 patients were transferred to acute care in main hospital, due to increased capacity in system

Conclusion. We safely cared for patients recovering from COVID-19 infection in an MHU to support system healthcare capacity. Our experience, including the specific hierarchy of controls implemented, may be helpful for future pandemic planning.

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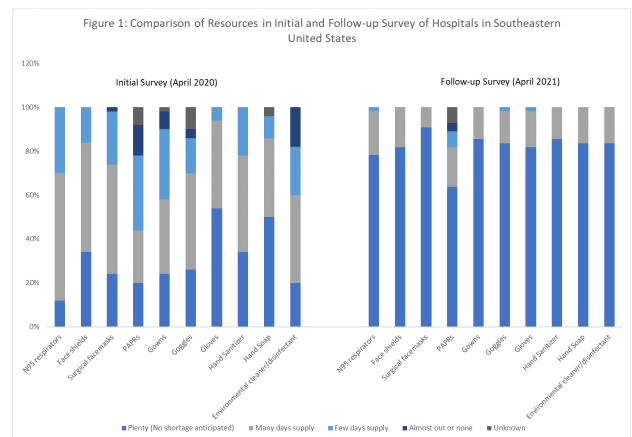
424. The Impact of COVID-19 Response on Infection Prevention Programs and Practices in Southeastern United States

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Background. Early assessments of COVID19 preparedness reported resource shortages, use of crisis capacity strategies, variations in testing, personal protective equipment (PPE), and policies in US hospitals. One year later, we performed a follow-up survey to assess changes in infection prevention practice and policies in our diverse network of community and academic hospitals.

Methods. This was a cross-sectional electronic survey of infection preventionists in 58 hospitals within the Duke Infection Control Outreach Network (community) and Duke/UNC Health systems (academic) in April-May 2021 to follow-up our initial survey from April 2020. The follow-up survey included 26 questions related to resource availability, crisis capacity strategies, procedures, changes to PPE and testing, and staffing challenges.



Results. We received 54 responses (response rate, 93%). Facilities reported significantly fewer PPE and resource shortages in the follow-up survey compared to our initial survey (Figure 1, P < 0.05). Only 32% of respondents were still reprocessing N95 respirators (compared to 73% in initial survey, P < 0.05). All hospitals performed universal masking, universal symptom screening on entry, and 30% required eye protection. In 2020, most hospitals suspended elective surgical procedures in March-April, and restarted in May-June. Approximately 92% reported in-house testing for SARS-CoV-2 by April 2020, at least a third of which had a weekly capacity of >100 tests. Almost 80% performed universal pre-operative testing, while 61% performed universal preadmission testing for SARS-CoV-2. Almost all hospitals switched from test-based to time-based strategy for discontinuing isolation precautions, majority in August-September 2020. Twenty-five percent hospitals reported infection prevention furloughs, staffing cuts, and or reassignments, while 81% reported increased use of agency nursing during the pandemic.

Conclusion. Our follow-up survey reveals improvement in resource availability, evolution of PPE guidance, increase in testing capacity, and burdensome staffing changes. Our serial surveys suggest increasing uniformity in infection prevention policies, but also highlight the increase in staff turnover and infection prevention staffing shortages.

Disclosures. Sonali D. Advani, MBBS, MPH, Nothing to disclose David J. Weber, MD, MPH, PDI (Consultant)

425. Sustained Control and Prevention of COVID-19 Outbreaks in Detroit Skilled Nursing Facilities

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