

Table 1. Areas of COVID-19 management lacking consensus. Not all respondents answered every question. The percentage in brackets was calculated with the number of respondents per question as the denominator.

Areas lacking consensus for COVID-19 management	Number N=24 (%)
<b>When would you consider removing a patient with COVID-19 from additional precautions?</b>	
• At least 14 days from symptom onset or first positive test whichever is later	11 (45.8)
• At least 2 negative NPS (24h apart) after 14days from symptom onset or first positive test	5 (20.8)
• At least 3 days asymptomatic (excluding post viral cough)	3 (12.5)
• At least 14 days from symptom onset or symptom resolution, whichever is longer	1 (4.2)
• At least 28 days from symptom onset when no follow-up testing is done	1 (4.2)
<b>Other single responses:</b>	
• At least 10 days asymptomatic (excluding post viral cough)	1 (4.2)
• Asymptomatic (with exception of post viral cough) and two negative NP swabs taken 24 hours apart.	1 (4.2)
• 10 days after symptom onset if never hospitalized/ unwell	1 (4.2)
• 40 days post symptom onset or 2 negative swabs 24 hours apart	1 (4.2)
• 14 days from symptom onset and asymptomatic X 3 days whichever is longer	1 (4.2)
• Variable approach depending on patient characteristics (inpatient vs. outpatient, adult vs. child, immunocompromised, etc.)	1 (4.2)
<b>Populations of asymptomatic testing (n=21)</b>	
• In patient requiring high risk surgery (eg. ENT surgery) to dictate PPE requirements or delay of surgery	15 (71.4)
• In patients undergoing a planned AGMP (eg. elective intubation) to dictate N95 use	11 (52.4)
• Transfer to acute care from LTCF (long term care facilities)	9 (42.9)
• Discharging from acute care to LTCF (long term care facilities)	9 (42.9)
• Pre-bone marrow transplant - recipient	8 (38.1)
• Babies born to COVID-19 positive mom	8 (38.1)
• Health care worker returning post exposure to COVID case	6 (28.6)
• Pre-bone marrow transplant – donor	6 (28.6)
• All admissions	5 (23.8)
• Pre-immunosuppression	5 (23.8)
• Pre solid organ donor – recipient	5 (23.8)
• Pre solid organ donor – donor	5 (23.8)
• Health care worker returning from working at other facilities (eg. long term care facilities)	2 (9.5)
<b>Duration of unlikely COVID-19 survival on mask (n=18)</b>	
• <2 days	5 (27.8)
• 3 days	8 (44.4)
• >3 days	5 (27.8)
<b>Threshold for outbreak to be declared over (n=21)</b>	
• 14 days from last new case in staff and/or patients whichever is last	9 (40.9)
• 28 days from last new case (2 incubation periods) in staff and patients whichever is last	8 (36.4)
• 28 days (2 incubation periods) from last new case in patients	3 (13.6)
• 14 days from last new case in patients	3 (13.6)
• 7 days from last new case in patients (typical symptom onset interval)	2 (9.1)
<b>Using powered air-purifying respirators (PAPRs) for aerosol generating procedures involving COVID-19 (n=24)</b>	2 (8.3)
<b>Neck personal protective equipment (n=16)</b>	
• No	16 (69.6)
• Only for incubator or code blue stations	2 (12.5)
• Only for anesthesia	2 (12.5)
<b>Hair covers/bouffants (n=23)</b>	
• No	10 (43.5)
• Yes	3 (13.0)
• No response	6 (26.1)

Table 2. Procedures considered as aerosol generating medical procedures (AGMPs). Respondents (n=24) were allowed to select more than one option.

Potential AGMP Procedure	Number of respondents (%) (n=24)
Intubation, bronchoscopy	23 (95.8)
Bilevel Positive Airway Pressure (BIPAP) / Continuous positive airway pressure (CPAP)	23 (95.8)
Nebulized medications	22 (91.7)
High flow nasal cannula (O2) (e.g. AirVo)	18 (75)
Induced sputum	1 (4.2)
Care of intubated patients (due to potential ventilator disconnects)	10 (41.7)
Transport of intubated patient (staff within 2m)	10 (41.7)
Transport of intubated patient (airway/head of bed staff)	2 (8.3)
Ear Nose Throat or Airway/Thoracic procedures	18 (75)
Upper endoscopy	8 (33.3)
Caesarean section where risk of imminent intubation may occur, and surgical team stays in the room	7 (29.2)
Chest tube insertions (if underlying air leak)	7 (29.2)
Trans-esophageal echocardiography	3 (12.5)
Surgeries where aerosolization of non-pulmonary tissue (e.g. Orthopedic bone saw, or laser plume)	1 (4.2)
Urgent Procedures where patient is screen positive for: symptoms, travel	1 (4.2)

Table 3. Personal protective equipment (PPE) conservation strategies (n=24). Not all respondents answered every question. The percentage in brackets was calculated with the number of respondents per question as the denominator. NA corresponds to the question not asked in the survey.

PPE Conservation Strategy	N95 respirators N (%)	Surgical masks N (%)
No reuse - For single patient encounter only	9 (37.5)	NA
Extended use - Use in between multiple patients	11 (45.8)	NA
Reprocessed and returned back to same user	3 (12.5)	NA
Reprocessed and given to any health care worker	1 (4.2)	NA
Maximum duration of use is until becomes wet or visible soiled	19 (90.5)	NA
Planning for potential reprocessing	13 (54.2)	1 (4.3)
<b>Method of reprocessing:</b>		
STERIS/STERRAD machine	10 (62.5)	0 (0)
Hydrogen peroxide	4 (25)	1 (100)
Steam	2 (12.5)	1 (100)
UV disinfectant	3 (18.8)	1 (100)

**Conclusion:** Across Canada, while there are areas of consensus in outbreak definitions, universal masking of clinical staff. There is significant variation in practice with respect to discontinuing additional precautions or outbreak measures, asymptomatic testing, AGMP definitions, PPE conservation strategies including reprocessing. As evidence evolves, national infection control guidelines will be important to improve standardization of practice and optimize patient care and staff safety.

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#### 493. Clinical and Epidemiological Features of Healthcare Workers Detected with Coronavirus Disease

Melissa Campbell, MD<sup>1</sup>; Rupak Datta, MD<sup>2</sup>; Anne Wyllie, PhD<sup>1</sup>; Arnau Casanovas-Massana, MSc, PhD<sup>1</sup>; Ryan Handoko, MD<sup>1</sup>; Lorenzo Sewanan, BS<sup>1</sup>; Albert I. Ko, MD<sup>3</sup>; Richard A. Martinello, MD<sup>1</sup>; <sup>1</sup>Yale School of Medicine, New Haven, Connecticut; <sup>2</sup>Yale School of Medicine - Yale New Haven Hospital, 20 York Street, Connecticut; <sup>3</sup>Yale School of Public Health, New Haven, Connecticut

**Session:** P-17. COVID-19 Infection Prevention

**Background:** Data early in the SARS-CoV-2 pandemic suggested frontline healthcare workers (HCW) may account for 10–20% of all infections. CDC estimated 600,000 infections in HCWs. Symptom screening is a strategy to prevent healthcare-associated transmission. This method may not identify asymptomatic or pre-symptomatic carriers.

**Methods:** We conducted a prospective cohort study in asymptomatic or minimally symptomatic healthcare workers in a 1541-bed academic medical center. Although recruitment began in designated COVID-19 units, we expanded to all HCWs providing care to hospitalized patients during the pandemic. Data was gathered on demographics, work area in the hospital and daily questionnaires were sent listing symptoms of SARS-CoV-2. Protocol included twice weekly self-collected nasopharyngeal swab and saliva for SARS-CoV-2 N1 and N2. Those with positive PCR result, underwent telephone survey to assess symptomatology and severity of illness.

**Results:** A total 525 HCWs began the study protocol and 16 were identified as PCR positive. Samples included concordant saliva and NP samples on 9 (56%), exclusively NP samples on 5 (31%) and 2 (12%) HCWs were positive by saliva PCR only. Majority were female, and all were nursing staff; with 19% reported not working in a designated COVID-19 unit. During the course of this active surveillance, universal masking was mandated in the institution. Rhinorrhea and headache were reported by 6 (38%), 5 (31%) reported cough and 3 (19%) developed myalgia. Changes in smell and taste preceded the positive PCR test in 2 (12%). One HCW reported developing a fever with acute illness. All were notified about their PCR positive status by institution's occupational health department and self-isolated to monitor for symptoms.

**Conclusion:** The spectrum of disease in this HCW cohort is similar to mild disease in the community. Due to high incidence of asymptomatic or mildly symptomatic HCWs, active surveillance with routine testing proves beneficial to prevent hospital transmission of SARS-CoV-2. Universal masking significantly decreased the HCW positive rate in our study, underscoring the need for universal efforts to mitigate healthcare-associated transmission with self-monitoring, face mask use, and other infection prevention behaviors like hand hygiene.

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#### 494. COVID-19 Outbreak: A Tale of Two Psych Units

Marilou Corpuz, MD<sup>1</sup>; Ruchika Jain, MBBS, MD<sup>2</sup>; Gregory Weston, MD MSCR<sup>3</sup>; Priya Nori, MD<sup>1</sup>; Priya Nori, MD<sup>1</sup>; Carmel Boland-Reardon, RN<sup>1</sup>; Evan Bernard, MS, CPHQ<sup>1</sup>; Esther Graham, RN, CIC<sup>1</sup>; Theresa Madaline, MD<sup>1</sup>; <sup>1</sup>Montefiore Medical Center, Bronx, New York <sup>2</sup>Montefiore Medical Center Bronx NY and Albert Einstein College of Medicine, Hartsdale, New York <sup>3</sup>Montefiore Medical Center and Albert Einstein College of Medicine, Bronx, New York <sup>4</sup>Montefiore Medical Center/Albert Einstein College of Medicine, New York, New York

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**Background:** COVID infections in inpatient psychiatry units present unique challenges during the pandemic, including behavioral characteristics of the patients, structural aspect of the unit, type of therapy for the patients. We present COVID outbreaks in psychiatry units in two hospitals in our medical center in Bronx, NY, and describe our mitigation strategies.