

10%). The most frequent infection-related calls were about tuberculosis (17%), gram-negative organisms (14%), and influenza (9%). During the COVID-19 period, the median monthly call volume increased 500% to 368 per month (range, 149–829) were COVID-19 related. The median monthly number of COVID-19 calls was 302 (range, 45–674). The median monthly number of non-COVID-19 calls decreased to 56 (range, 36–155). The most frequent call sources were inpatient units (57%), outpatient clinics (16%), and the department of public health (5%). Most calls concerned isolation and precautions (50%) and COVID-19 testing (20%). The mean time required to respond to each question was 10 minutes (range, 2–720). The biggest surges in calls during the COVID-19 period were at the beginning of the pandemic (March 2020) and during the hospital peak COVID-19 census (November 2020). **Conclusions:** In addition to supporting a proactive COVID-19 response, our IPC program experienced a 500% increase in consultation requests. Planning for future bioemergencies should include creative strategies to provide additional resources to increase response capacity within IPC programs.

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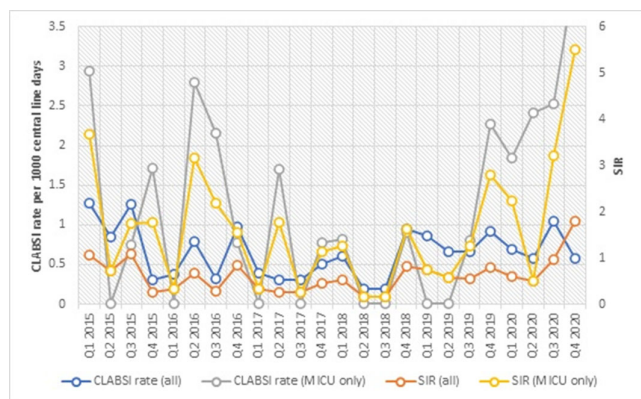
Poster Presentation

**Subject Category:** COVID-19

**The Impact of Coronavirus Disease 2019 (COVID-19) Pandemic on Device-Associated Healthcare-Associated Infection**

Minji Kang; Sharen Henry; Elizabeth Thomas; Doramarie Arocha and Julie Trivedi

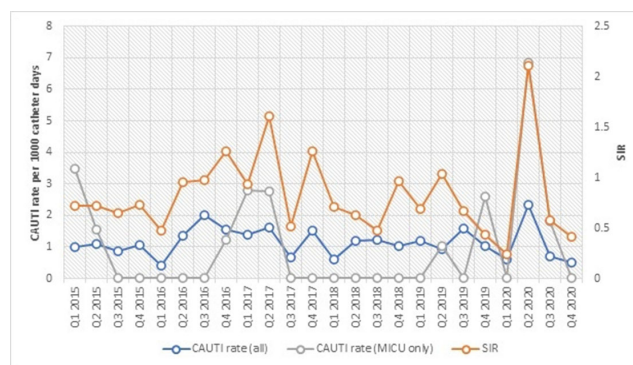
**Background:** The impact of the coronavirus disease 2019 (COVID-19) pandemic on healthcare-associated infection (HAI) is not yet known. Diversion of resources from traditional HAI surveillance and prevention efforts toward institutional COVID-19 response, along with decrease in patient contact due to fear or required quarantine or isolation, may have increased HAI rates. In contrast, increased compliance with hand hygiene and personal protective equipment may have decreased HAI rates. **Methods:** We sought to determine the impact of COVID-19 pandemic on healthcare-associated central-line-associated bloodstream infection (CLABSI) and catheter-associated urinary tract infection (CAUTI). CLABSI and CAUTI rates and standardized infection ratios (SIRs) reported to the NHSN from the first quarter of 2015 to the fourth quarter of 2020 were obtained for the entire facility and for the medical intensive care unit (MICU), which was converted during the pandemic to an intensive care unit solely for critically ill patients with COVID-19. Changes in CLABSI and CAUTI rates and SIRs before the pandemic (Q1 2015 to Q4 2019) and during the pandemic (Q1 2020 to Q4 2020) were assessed using an independent-sample *t* test. **Results:** The CLABSI rate was unchanged, with a mean (SD) of 0.64 ( $\pm 0.34$ ) CLABSIs per 1,000 central-line days before the pandemic and 0.72 ( $\pm 0.22$ ) during the pandemic ( $P = .62$ ) (Figure 1). The SIR remained stable



**Figure 1.**

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**Figure 2.**

at 0.54 ( $\pm 0.29$ ) before and 0.96 ( $\pm 0.59$ ) during the COVID-19 pandemic ( $P = .25$ ). However, CLABSI rate in MICU increased significantly from 0.92 ( $\pm 1.00$ ) to 2.75 ( $\pm 1.00$ ) ( $p < 0.01$ ), along with SIR from 0.81  $\pm$  0.89 to 2.53  $\pm$  1.07 ( $p < 0.01$ ) (Figure 1). CAUTI rate was unchanged with 1.17  $\pm$  0.38 CAUTI per 1000 catheter days per quarter before, and 1.04  $\pm$  0.87 during COVID-19 pandemic ( $p = 0.64$ ). CAUTI SIR remained stable at 0.82  $\pm$  0.31 before and 0.83  $\pm$  0.86 during COVID-19 pandemic ( $p = 0.96$ ). CAUTI rate in MICU was 0.78  $\pm$  1.20 before and 2.17  $\pm$  3.24 after COVID-19 pandemic ( $p = 0.45$ ) (Figure 2). **Conclusions:** Although our institutional CLABSI and CAUTI rates and SIRs remained unchanged, our medical intensive care unit, which housed our critically ill patients with COVID-19, experienced significant increases in CLABSI rate and SIR. This finding is likely multifactorial in the setting of overextended nursing staff, use of prone position, and challenges of infection prevention efforts under isolation precautions.

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**Subject Category:** COVID-19

**The Impact of COVID-19 on Patient Safety: A Survey of Acute-Care Registered Nurses in New Jersey**

Monika Pogorzelska-Maziarz; Mary Lou Manning; Angela Gerolamo; Mary Johansen; Irina Grafova; Suzie Crincoli and Pamela de Cordova

**Background:** As the world grapples with the pandemic of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), it is important to consider the full impact of coronavirus disease 2019 (COVID-19) on healthcare delivery. Evidence from outbreaks of novel H1N1 and Ebola indicates that response to these types of outbreaks requires extraordinary resources, which are diverted from routine infection prevention and control activities. However, little is known about the impact of COVID-19 on adherence to patient safety protocols in hospitals, including infection prevention and control activities. We have described the reports of acute-care registered nurses (RNs) in adhering to patient safety protocols while delivering care to COVID-19 patients. **Methods:** In October 2020, we conducted a cross-sectional electronic survey of all active RNs in the state of New Jersey who provided direct patient care in a New Jersey hospital in an emergency or adult inpatient unit during the onset of the COVID-19 pandemic. **Results:** More than 3,027 RNs participated in the survey, for a 15% response rate based on number of eligible RNs. Moreover, 15% of respondents reported that they tested positive for COVID-19 during the initial peak of COVID-19 in New Jersey (March–June 2020). Most RNs reported that the number of patients they were assigned during the first peak of the pandemic affected their ability to adhere to patient safety protocols (eg, deep-vein thrombosis screening, central-line bundles, pressure ulcer prevention). In open-ended responses, they shared that being understaffed, the extra time it took for donning and doffing of PPE, the lack of access to ancillary staff (ie nursing assistants,