

shifts at additional quantiles, which would provide additional evidence that TBE is a metric that can be used for setting benchmarks and can serve as a signal of CLABSI prevention progress.

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Poster Presentation

**The Burden of Gastroenteritis Outbreaks in Long-Term Care Settings in Philadelphia, 2009–2018**

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**Background:** Gastroenteritis causes significant morbidity and mortality in long-term care facility (LTCF) residents, a growing population within the United States. **Methods:** We conducted a retrospective cross-sectional study in LTCFs in Philadelphia County from 2009 to 2018. Outbreak characteristics and interventions were extracted from Philadelphia Department of Public Health's (PDPH) database, and quality data on all LTCFs was extracted from the CMS Nursing Home Compare database. **Results:** We identified 121 gastroenteritis outbreaks in 49 facilities. Numbers of affected patients ranged from 2 to 211 patients (median patient attack rate, 17%). Staff were reported ill in 94 outbreaks (median staff attack rate, 5%). Outbreak facilities were associated with higher occupancy rates (91% vs 88%;  $P = .033$ ) and total bed numbers (176 vs 122;  $P = .071$ ) when compared to nonoutbreak facilities. Higher rates of staff illness were associated with prolonged outbreaks (13% vs 4%;  $P < .001$ ) and higher patient illness rates (9% vs 4%;  $P = .012$ ). Prolonged outbreaks were associated with lower frequency of cohorting for outbreak management (13% vs 41%;  $P = .046$ ). **Conclusions:** This study is the largest published analysis of gastroenteritis outbreaks in LTCFs. Facility characteristics and staff disease activity were associated with more severe outbreaks. Heightened surveillance for gastrointestinal symptoms among staff and increased use of cohorting might reduce the risk of prolonged gastroenteritis outbreaks in LTCF.

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**The Daily Direct Costs of Isolating Patients Identified With Highly Resistant Microorganisms**

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**Background:** Isolation precautions are recommended when caring for patients identified with highly resistant microorganisms (HRMOs). However, the direct costs of isolating patients are largely unknown. Therefore, we aimed to obtain detailed information on the daily direct costs associated with isolating patients

identified with HRMO. **Methods:** This study was performed from November until December 2017 on a 12-bed surgical ward. This ward contained solely isolation rooms with an anteroom. The daily direct costs of isolation were based on three cost items: (1) additional personal protective equipment (PPE); measured by counting the consumption of empty packaging materials, (2) cleaning and disinfection of the isolation room; based on the costs of an outsourced cleaning company, and (3) additional workload for health-care workers; based on literature and multiplied by the average gross hourly salary of nurses. A distinction was made between the costs for strict isolation, contact-plus isolation, and contact isolation. **Results:** During the study period, 26 patients were nursed in isolation because of HRMO carriage, resulting in a total of 304 isolation days (median 7 isolation days; range 1–44). Gloves were consumed the most and hair caps the least. The average daily direct costs of isolation were the least expensive for contact isolation, €28/\$31, and the most expensive for strict isolation, €41/\$47. **Conclusions:** By using a novel, easy method to estimate consumption of PPE, we conclude that the daily direct costs of isolating a patient, differs per type of isolation. Insight into the direct costs of isolation is of utmost importance when developing or revising policies.

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**The Development of an Environmental Surveillance Protocol to Detect *Candida auris* and Measure the Adequacy of Discharge Room Cleaning Performed by Different Methods**

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**Background:** Contaminated surfaces within patient rooms and on shared equipment is a major driver of healthcare-acquired infections (HAIs). The emergence of *Candida auris* in the New York City metropolitan area, a multidrug-resistant fungus with extended environmental viability, has made a standardized assessment of cleaning protocols even more urgent for our multihospital academic health system. We therefore sought to create an environmental surveillance protocol to detect *C. auris* and to assess patient room contamination after discharge cleaning by different chemicals and methods, including touch-free application using an electrostatic sprayer. Surfaces disinfected using touch-free methods may not appear disinfected when assessed by fluorescent tracer dye or ATP bioluminescent assay. **Methods:** We focused on surfaces within the patient zone which are touched by the patient or healthcare personnel prior to contact with the patient. Our protocol sampled the over-bed table, call button, oxygen meter, privacy curtain, and bed frame using nylon-flocked swabs dipped in nonbacteriostatic sterile saline. We swabbed a 36-cm<sup>2</sup> surface area on each sample location shortly after the room was disinfected, immediately inoculated the swab on a blood agar 5% TSA plate, and then incubated the plate for 24 hours at 36°C. The contamination with common environmental bacteria