Results. The most common Gram-negative organisms were Klebsiella pneumoniae and Escherichia coli. Extended-spectrum β-lactamase (ESBL) producing E. coli and K. pneumoniae were common (Figure 1). The average rates of ESBL E. coli and K. pneumoniae were 55% and 64%. The total average DDD/1,000 was 83. The average DDD/1,000 per drug is graphed in Figure 2.

Figure 1. Percentage of ESBL producing EC and KP.

Conclusion. Ceftriaxone and cefazolin were the most commonly prescribed antimicrobials. Rates of ESBL-producing EC and KP are high at HGHS, with average rates above 50%. This differs greatly from reported prevalence in the United States. Thus, local treatment guidelines need to be established and may differ from Infectious Diseases Society of America guidelines. Further studies are needed to identify the clinical characteristics and risk factors of patients with ESBL in the DR. This will help local ASP programs identify and advise carbapenem use for patients at risk.

Disclosures. All authors: No reported disclosures.

1780. Results of a Successful Implementation of an Antimicrobial Stewardship Program in a Public Hospital in São Paulo, Brazil
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Session: 216. Antimicrobial Stewardship: Global Perspectives
Saturday, October 6, 2018: 12:30 PM

Background. The implementation of antimicrobial stewardship program is one of the basis for the control of multidrug-resistant bacteria (MDR) and the reduction of unnecessary costs, especially in public hospitals. The use of a multimodal strategy is fundamental to the success of a stewardship program.

Methods. This is an analysis of antimicrobial consumption in intensive care unit (ICU) of a public hospital in São Paulo, Brazil, before and after the implementation of the antibiotic stewardship program. In the pre-intervention period—January 2014 to December 2015—the rational use of antimicrobials was based only on postprescription authorization by the infectious diseases doctor. Since January 2016 was established an antibiotic stewardship program based on authorization of antimicrobial use, implementation of an empirical antibiotic protocol according to institutional microbiological profile, measurement of adherence to the protocol and feedback to the leadership, pharmaceutical intervention, educational measures for medical staff and leadership engagement to the program. We compared consumption in DDD per 1,000 patient-days (1,000/pd) and mean cost with antimicrobials in the medical staff and leadership engagement to the program. We compared consumption to the leadership, pharmaceutical intervention, educational measures for antimicrobial use, implementation of an empirical antibiotic protocol according to institutional microbiological profile, measurement of adherence to the protocol and feedback to the leadership, pharmaceutical intervention, educational measures for medical staff and leadership engagement to the program. We compared consumption in DDD per 1,000 patient-days (1,000/pd) and mean cost with antimicrobials in the medical staff and leadership engagement to the program. We compared consumption in DDD per 1,000 patient-days (1,000/pd) and mean cost with antimicrobials in the medical staff and leadership engagement to the program.

Results. A total of 401, 381, and 379 patients were recruited in the baseline, intervention, and follow-up phases. Baseline characteristics of the three groups were similar. Antimicrobial use decreased from 831.5 during baseline to 717 DOT per 1,000 patient days in the intervention (P < 0.0001) and the effect was sustained in the follow-up period (713.6 DOT per 1,000 patient-days). Among the study antimicrobials, DOTs were significantly lower in the intervention vs. baseline phase for Quinolones (21.5 vs. 33.3), Carbapenems (340.2 vs. 426.0) and Colistin (131.5 vs. 155.9) (P < 0.0001). De-escalation according to clinical resistance was significantly higher in the intervention group compared with the baseline (42.7% vs. 23.6%; P < 0.0001). Compliance to hospital-based antibiotic guidelines significantly improved in intervention and follow-up phases compared with the baseline (19.5%, 21.8%, 33.2%; P < 0.0001). We found that 73.3% of antibiotic prescriptions were inappropriate and commonly occurred in the absence of an appropriate clinical indication. Recommendations by the ID team were accepted in 66.7% of the cases. All-cause in-hospital mortality rates were 22.4% and 27.6% in the baseline and intervention phases respectively (P = 0.093).

Conclusion. An ID physician-driven antimicrobial stewardship program was successful in reducing antibiotic utilization without compromising patient safety in low and middle-income countries; however, this needs further validation.

Disclosures. All authors: No reported disclosures.

1782. Guideline-Discordant Carbapenem Prescribing Policies at a Large, Urban Hospital in Manila, Philippines
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Background. Hospital antimicrobial stewardship programs are critical in countries such as the Philippines, where antibiotic-resistant infections are highly prevalent. At our institution, a Prior Antibacterial Restriction Approval (PARA) is required for noninfectious disease specialists to prescribe carbapenems. PARA request forms include specification of empiric or definitive therapy based on diagnostic tests. Recommended duration of therapy is typically 3 days for empiric use and 7 days for definitive, with possible extension upon specialist approval.

Methods. The study took place at an 800-bed tertiary hospital in Manila, Philippines. Using retrospective chart review, patients with a PARA request for carbapenems between January and December 2016 were identified. Information on patient demographics, hospital stay, infection, treatment, and outcomes was collected using the hospital’s online record system. Carbapenem use was scored as concordant or discordant based on guidelines of the Infectious Diseases Society of America: de-escalation based on culture data, length of carbapenem therapy, and/or consultation with an Infectious Disease Specialist.

Results. Of 183 patients on carbapenem therapy, 56 (31%) were classified as definitive and 127 (69%) were empiric (Table 1). In addition, 56 (44%) of the patients on antibiotic therapy were found to be guideline discordant. The primary reason for discordance was failure to de-escalate the carbapenem following culture results (80% of cases with empiric prescriptions).

Conclusion. Patients who were prescribed carbapenems empirically were more likely to have overall discordant therapy, which was often due to unnecessarily long antibiotic courses or failure to revise treatment based on laboratory data.