Results. at June 3rd, 2021, we evaluated all 5,570 Brazilian cities (Figure 1): 2,708 cities (49%) with COVID-19 normality rate less than 50% (full schools closure), 2,223 cities (40%) with normality rate between 50% and 70% (in-person learning only for 5 years and 8 months-old children), 583 cities (11%) with normality rate between 71% and 80% (in-person learning extended to children age 12 years and less), 583 cities (1%) with normality rate between 81% to 90% (in-person learning extended to the student population age 18 years), and just one city with 92% COVID-19 normality rate (in-person learning extended to all the student population). We calculated the COVID-19 normality rate between January and May, 2021, in four countries: Brazil, USA, UK, and Italy (Figure 2). At Jun, 3rd, 2021, percentage of people fully vaccinated in Brazil varied from 0% to 69%, an average of 11%.

Conclusion. COVID-19 vaccination programs take several months to implement. Besides fully vaccination of the population, it is important to check if people became really safe from the virus. The COVID-19 Normality Rate is a double check multivariate score that can be used as a criteria for optimal time to return to in-person learning safely.

Disclosures. All Authors: No reported disclosures

405. A Qualitative Study Based on a Case Series of Obstetric COVID-19 Patients to Determine Risks in Management Associated with Severity in a Government Hospital in the Philippines
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Session: P-17. COVID-19 Global Response/Response in Low Resource Settings
Background. Enterprise Risk Management (ERM) in healthcare is a method used to identify, assess and reduce risk to patients and the hospital organization. The objective of this study is to identify clinical and organizational challenges and risks in healthcare management caused by COVID-19, and its impact on patients and healthcare workers, in a low-resource obstetric setting.

Methods. From a census of patients from 1 April 2020 to 30 July 2020, four cases of COVID-19 in pregnancy representing different severity levels were selected. A patient tracer activity was done for each patient, documenting events that the patient and healthcare team experienced from admission to discharge. A case series on these patients was written. A focus group consisting of an OB-GYN resident, OB-GYN consultant, OB-GYN nurse, OB-GYN infectious disease consultant, and internal medicine resident and consultant, was formed. Each case was presented to the focus group to establish the context of risk assessment. Risks were identified using the framework of Enterprise Risk Management. Each risk was classified according to their risk domain and severity. Root cause analysis showed that common causes of risks were due to exposure to asymptomatic patients and delayed and false-negative swab results.

Conclusion. The results of this study may be used towards the final steps of ERM: risk evaluation, treatment and management, in a low resource setting.

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406. Incidence of Community and Hospital Acquired Infections in Critically Ill COVID-19 Patients in the Dominican Republic
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Session: P-17. COVID-19 Global Response/Response in Low Resource Settings
Background. The disease caused by SARS-CoV-2, COVID-19, has caused a global public health crisis. COVID-19 causes lower respiratory tract infection (LRTI) and hypoxia. There is a paucity of data on bacterial and fungal coinfection rates in patients with COVID-19 at low and middle income countries (LMICs). Our objective is to describe the clinical characteristics of critically ill patients with COVID-19 in the Dominican Republic (DR)

Methods. We performed a retrospective review of patients admitted to the ICU with COVID-19 from March 14th to December 31st 2020, at a 296-bed tertiary care level and teaching Hospital in the Dominican Republic. Demographic and clinical information was collected and tabulated. Laboratory confirmed bacterial and fungal infections were defined as community acquired infections (CAI) if diagnosed within 48 hours of admission and hospital acquired infections (HAI) when beyond 48 hours. Microbiologic data was tabulated by source and attribution.

Results. Our cohort had 382 COVID-19 patients. Median age was 64 and most were male (64.3%) and 119 (31.1%) were mechanically ventilated and 200 (52%) had central venous catheters. A total of 28 (7%) laboratory confirmed community acquired infections and 55 (14%) HAI occurred. Community acquired infections included 13 (46%) bloodstream infections (BSIs), 11 (39%) urinary tract infections (UTIs) and 6 (21%) LRTIs. HAs included 39 (70%) BSIs, 11 (20%) UTIs and 6 (11%) ventilator associated pneumonias (VAP). Causal organisms of community and hospital acquired BSIs and UTIs are in Figure 1 and Figure 2 respectively. All-cause mortality was 35.3% (135/382) in our cohort, and 100% mortality (76) in those with coinfections.