Conclusion. Practitioners who were low prescribers for antibiotics were also likely to be low prescribers for antipsychotics, suggesting judicious use for both classes of medications. Further understanding of the behaviors of these individuals, as well as those who are high prescribers for both classes, has implications for improving antibiostewardship practices in nursing homes.

Disclosures. Robin L. Jump, MD, PhD, Pfizer (Individual(s) Involved: Self): Consultant

136. Attitudes and Practices of Antimicrobial Resistance and Antimicrobial Stewardship at the Uganda Cancer Institute

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Session: P-08. Antimicrobial Stewardship: Special Populations

Background. As access to cancer treatment has increased in sub-Saharan Africa (sSA), infection-related complications are a growing concern. Little is known about infection management practices in this setting. Understanding the unique challenges to diagnosing and treating infections can inform the development of targeted strategies to improve infection management for cancer treatment programs throughout sSA.

Methods. We conducted a cross-sectional survey of doctors, nurses, and pharmacists at the Uganda Cancer Institute (UCI), a national cancer referral hospital in Kampala, Uganda. The 25-item survey was designed to assess staff knowledge of antimicrobial resistance and antimicrobial stewardship, investigate antibiotic decision-making practices, and identify barriers to diagnosing and treating infections.

Results. Of the 61 respondents, 25 (41%) were doctors, 7 (11%) were pharmacists, and 29 (48%) were nurses. In total, 98% (60/61) had heard of the term “antimicrobial resistance” and 84% (51/61) agreed that antimicrobial resistance is an important problem at UCI. Multiple factors were felt to contribute to antimicrobial resistance including the use of too many antibiotics, patient insistence on antibiotics, and poor patient adherence (Fig 1). While 72% (44/61) had heard of the term “antimicrobial stewardship,” only 25% (15/61) knew a lot about what it meant. Numerous factors were considered important to antibiotic decision-making including patient white blood cell count and severity of illness (Fig 2). Perceived barriers to infection diagnosis included the inability to obtain blood cultures and to regularly measure patient temperatures; perceived barriers to obtaining blood cultures included patient cost and availability of supplies (Fig 3).

Percentages shown next to bars represent the combined total percentage of respondents reporting that the factor does not or usually does not contribute (left of bars, main chart), occasionally or frequently contributes (right of bars, main chart), or neither contributes nor does not contribute (right of neutral chart).

Figure 2. Factors that doctors, pharmacists, and nurses working at the Uganda Cancer Institute (UCI) perceive as contributing to antimicrobial resistance at the UCI.

Figure 2. Factors that doctors, pharmacists, and nurses working at the Uganda Cancer Institute consider to be important when choosing antibiotics to treat infections.

Percentages shown next to bars represent the combined total percentage of respondents reporting that the factor is somewhat or very unimportant (left of bars,
Figure 3. Factors that doctors, pharmacists, and nurses working at the Uganda Cancer Institute perceive as limiting the ability to diagnose infections and obtain blood cultures.

**Limitations in Infection Diagnosis:**
- Inability to obtain blood cultures: 93%
- Inability to regularly measure patient temperatures: 79%
- Delay in receiving lab results: 59%
- Inability to obtain other infectious testing: 70%
- Inability to obtain imaging: 59%

**Limitations in Blood Culture Availability:**
- Patient cost: 91%
- Culture supplies unavailable: 89%
- Delays in obtaining culture results: 53%
- Inability to transport culture bottles to lab: 87%
- Staff availability to draw cultures: 50%

**Conclusion.** While most staff recognized the term “antimicrobial resistance” and identified this as a major local problem, fewer were familiar with the term “antimicrobial stewardship.” We identified numerous perceived barriers to infection diagnosis and treatment, including the ability to consistently measure temperatures and the cost of blood cultures. A multipronged approach is needed to improve staff knowledge of antimicrobial stewardship and to address the systemic barriers to infection management at UCI.

**Disclosures.** All Authors: No reported disclosures

137. Impact of Antimicrobial Stewardship Interventions on Post- Elective Caesarean Antibiotic Prophylaxis and Surgical Site Infections

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**Methods.** This pre-post quasi-experimental study was conducted over 9 months (2 months pre- and 7 months post-intervention) in all women admitted for eLSCS in our institution. Interventions included eLSCS surgical prophylaxis guideline dissemination, where a single antibiotic dose within 60 minutes before skin incision was recommended (2 months pre- and 7 months post-intervention) in all women admitted for eLSCS in our institution. Interventions included eLSCS surgical prophylaxis guideline dissemination, where a single antibiotic dose within 60 minutes before skin incision was recommended. Post-eLSCS oral antibiotics use was actively discouraged in those without SSI risk factors. This was followed by ASP intervention notes (phase 1) for 3 months, and an additional phone call to the ward team for the next 7 months (phase 2). Phase 3 (next 6 months) constituted speaking to the operating consultant. The primary outcome was post-operative oral antibiotics prescription rates. Secondary outcomes included rates of 30-day post-operative SSI.

**Results.** A total of 1751 women was reviewed. Appropriateness of pre-operative caesarean (eLSCS) oral antibiotic prophylaxis use and patient outcomes including SSI rates.

**Conclusion.** While most staff recognized the term “antimicrobial resistance” and identified this as a major local problem, fewer were familiar with the term “antimicrobial stewardship.” We identified numerous perceived barriers to infection diagnosis and treatment, including the ability to consistently measure temperatures and the cost of blood cultures. A multipronged approach is needed to improve staff knowledge of antimicrobial stewardship and to address the systemic barriers to infection management at UCI.

138. Implementation of an Antimicrobial Stewardship Order Set in the Emergency Department at a Quaternary Care Facility

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**Session:** P-08. Antimicrobial Stewardship: Special Populations

**Background.** Implementation of antimicrobial stewardship (AS) interventions in the emergency department (ED) has been associated with improved patient outcomes. One potentially promising AS strategy is the implementation of an ED-specific, evidence-based antimicrobial order set. In this study, we examined the impact of implementing an ED-specific order set (EDOS) on the appropriateness of empiric antimicrobial therapy.

**Methods.** We conducted a pre-post quasi experimental study on 160 adult patients presenting to the ED with suspected or confirmed common infections at our quaternary healthcare facility. The EDOS was implemented in December 2020, providing evidence-based recommendations for the management of common infectious diseases. Data was collected between September 2019 and March 2020 for the pre-EDOS implementation group and between January 2021 and April 2021 for the post-EDOS implementation group.

**Results.** A total of 100 ED patients pre-EDOS implementation and 60 patients post-EDOS implementation were compared. At baseline, patients in the post-EDOS group were older (59.8±20.30 years vs. 50.17±19.97 years, P=0.0037). A higher number of patients in the post-EDOS group had a history of multiple comorbidities (76.67% vs. 54%, P=0.0039). There was a higher rate of appropriate antimicrobial use in the post-EDOS group as compared to the pre-EDOS group (88.3% vs. 50%, P=0.001). Longer hospital stays were observed in the post-EDOS group (P=0.0005). Clinical cure was similar between the two groups (96.6% vs. 94%, P=0.4568).

**Conclusion.** In our study, we observed higher rates of appropriate antimicrobial selection after implementation of an EDOS. Use of an EDOS may represent a valuable AS intervention to guide appropriate antimicrobial prescribing in the ED, and larger studies are needed to confirm those findings.

**Disclosures.** All Authors: No reported disclosures

139. Improving Skin and Soft Tissue Infection Antibiotic Duration Concordance with National Guidelines in Pediatric Urgent Care Clinics

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**Session:** P-08. Antimicrobial Stewardship: Special Populations

**Background.** Skin and soft tissue infections (STIs) are the second most common diagnosis leading to pediatric antibiotic prescriptions in the outpatient setting after respiratory diagnoses. Children with STIs often receive > 7 days of antibiotics, although current guidelines recommend 5-7 days for most diagnoses. At Children’s Mercy Hospital (CMH) urgent care clinics (UCCL), only 58% patients received the recommended 5-7 days of antibiotics. We aimed to increase the percentage of patients receiving 5-7 days of oral antibiotics for STIs from 58% to 75% by December 31st, 2021.

**Methods.** We conducted a pre-post quasi experimental study on 160 adult patients presenting to the ED with suspected or confirmed common infections at our quaternary healthcare facility. The EDOS was implemented in December 2020, providing evidence-based recommendations for the management of common infectious diseases. Data was collected between September 2019 and March 2020 for the pre-EDOS implementation group and between January 2021 and April 2021 for the post-EDOS implementation group.

**Results.** A total of 100 ED patients pre-EDOS implementation and 60 patients post-EDOS implementation were compared. At baseline, patients in the post-EDOS group were older (59.8±20.30 years vs. 50.17±19.97 years, P=0.0037). A higher number of patients in the post-EDOS group had a history of multiple comorbidities (76.67% vs. 54%, P=0.0039). There was a higher rate of appropriate antimicrobial use in the post-EDOS group as compared to the pre-EDOS group (88.3% vs. 50%, P=0.001). Longer hospital stays were observed in the post-EDOS group (P=0.0005). Clinical cure was similar between the two groups (96.6% vs. 94%, P=0.4568).

**Conclusion.** In our study, we observed higher rates of appropriate antimicrobial selection after implementation of an EDOS. Use of an EDOS may represent a valuable AS intervention to guide appropriate antimicrobial prescribing in the ED, and larger studies are needed to confirm those findings.

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