Results. Of the 173 patients, 155 (90%) were successfully contacted post-discharge. The majority of needs identified were AM education, access, and coordination of care (Table 2). In addition, discrepancies between discharge orders, summary content, and patient instructions were prevalent. Based on the medication-related assessment performed by the ID-trained pharmacists, they were able to resolve AM-related issues and identify gaps, and link patients to appropriate multidisciplinary providers to coordinate care plans.

Conclusion. The data highlight the prevalence of immediate post-discharge needs related to antimicrobial for patients and the critical role of ID-trained pharmacists in addressing these needs. In a large public academic medical center with uninsured and underserved patients, additional support for AM access, education, and navigation of care plans is needed. For medically and socially complex ID patients, an ID-trained pharmacist plays a critical role in reducing risk inherent in the transition from inpatient to outpatient care.

Table 1. Summary of AM Needs and Content

| Contact + intervention | Contact - no intervention | Unable to contact |
|------------------------|--------------------------|------------------|
| Number of patients     | 93                       | 62               | 18               |

Table 2. Summary of ID DOOR Interventions: Patient Needs and Content

| Intervention | Contact + intervention | Contact - no intervention | Unable to contact |
|--------------|------------------------|---------------------------|------------------|
| Education    | 96                     | 42                        | 12               |
| Side effects | 12                     | 8                         | 12               |
| Amoxicillin  | 9                      | 9                         | 9                |
| Other questions | 8                     | 8                         | 8                |

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749. Wide Variation in the Use of External Cooling Blankets Among Adult Intensive Care Unit Nurses for Fever
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Background. There are limited data on whether external cooling blankets (ECBs) are beneficial in the treatment of fever that is not related to malignant hyperthermia (MH). There are no established national guidelines for the use of ECBs for fever other than for MH. Thus, there may be a wide variation in nursing practice related to their use.

Methods. We performed a cross-sectional survey of adult intensive care unit (ICU) nurses at our hospital, using SurveyMonkey®TM, to evaluate nurses' practices related to the use of ECBs in febrile patients other than for MH. Data collected from the survey included years of experience as an ICU nurse, type of ICU, when ECBs are used and temperature of initiation and discontinuation. Continuous variables were compared using Student’s t-test and categorical variables were described as frequency distributions. Data were analyzed using SPSS® 25.0 and a P-value of 0.05 or less was considered to indicate statistical significance.

Results. We invited 150 nurses to participate in the survey, 61 responded (40.7%). The mean number of years worked in an ICU was 8.6 ± 9.4 years (range: 1–34), 14 (23%) worked in a cardiovascular ICU (CVICU), 22 (36%) worked in a medical ICU (MICU), and 25 (41%) in a surgical ICU (SICU). A total of 58 (95.1%) of nurses reported using ECBs for fever, with 50 (82%) of nurses using ECBs only when other methods failed. MICU nurses (31.8%) were more likely to report using ECBs prior to failed attempt of other anti-pyretic methods than SICU (16%) and CVICU (10.0%) nurses. There was no association between initiation and termination of ECB use by ICU type, years of nursing experience or a given range of temperature values.

Conclusion. There was a wide variation of practice among ICU nurses as it relates to the use of ECBs in patients with fever. Medical ICU nurses tended to use ECBs before failure of other methods compared with other ICU nurses. Standardized protocols should be developed for their use based on existing medical literature. Further studies should be performed to confirm our findings.

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750. Serious Bacterial Infections: Successful Outpatient Management by Infectious Disease Physicians in Office Infusion Centers

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Background. Patients with serious bacterial infections (SBI), identified as bone and joint infections (BJI), bacteremia/endocarditis, and central nervous system (CNS) infections are frequently discharged on outpatient parental antimicrobial therapy (OPAT). They account for 48% of all infections treated in our network of Infectious Disease (ID) physician office infusion centers (POICs). Care for these patients poses risks and challenges to ensure safe and successful outcomes while avoiding hospitalizations. This study examines clinical outcomes and complications of our SBI patients receiving OPAT in ID POICs.

Methods. All patients were identified with SBI receiving OPAT in 2017 from 14 POICs. A group of 250 patients were randomly selected by incidence of diagnosis and a retrospective chart review performed. Demographics, treatment regimen, clinical
outcomes, adverse drug reactions (ADRs) and unplanned hospitalizations during OPAT were collected. Clinical success was defined as clinical cure or improvement at completion of OPAT. Patients were included who were hospitalized for <7 days and subsequently completed OPAT. ADRs leading to hospitalization or discontinuation of OPAT were deemed serious. Descriptive statistics were used for distribution of variables.

**Results.** SBI patients included BJI (n = 175), bacteremia/endocarditis (n = 60) and CNS infections (n = 15) as described in Table 1. Successful clinical outcomes were reported in 224 patients (89.6%) after a mean duration of OPAT of 32±20 days. Of these patients (6.7%) were hospitalized during OPAT and returned to the POIC for a successful clinical outcome. Clinical success rates for BJI, bacteremia/endocarditis and CNS infections were 89.1%, 91.6% and 86.7%, respectively. The primary reason for nonfavorable outcomes was worsening of infection (15/26, 58%). Serious ADRs were reported in 12 patients (4.8%) with (2.4%) leading to hospitalization. Unplanned hospitalizations during OPAT occurred in 33 patients (13.2%) with the majority (21/33, 64%) related to disease. ADRs and hospitalizations compare favorably to data previously reported. (Schmidt et al. OFID 16.4, 2017).

**Conclusion.** Patients with serious bacterial infections had high success rates when treated by an ID physician in infusion centers. Adverse events and unplanned hospitalization rates were low.

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**751. Study on Daptomycin Prescription Suitability as a First Step Towards an Antimicrobial Stewardship Program**

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**Background.** Daptomycin use has increased since its approval and has often been prescribed empirically, using nonadequate dosages and duration of therapy needs also an improvement. The follow-up of patients treated with daptomycin should be considered a priority intervention within an Antimicrobial Stewardship Program.

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**752. Timing of Antibiotics Administration in Emergency Department and Mortality in Sepsis by Sepsis-3 Definition**

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**Background.** Even after the introduction of the Sepsis-3 definition, there is still debate on the ideal antibiotic administration time in patients with sepsis. This study was performed to evaluate the association between the timing of antibiotic administration and mortality in sepsis patients who visited the emergency room.

**Methods.** A prospective cohort study was conducted on patients who were diagnosed as sepsis with Sepsis-3 definition among patients who visited the emergency department (ED) of Korea University Ansan Hospital from September 2017 to January 2019. The timing of antibiotic administration was defined as the time in hours from ED arrival until the first antibiotic administration. Cox logistic regression analysis was used to estimate the association between time to antibiotics and 7-, 14-, and 28-day mortality.

**Results.** During the study period, a total of 251 patients were enrolled with a 7-, 14-, and 28-day mortality of 16.7%, 36.3%, and 57.4%, respectively. The median time to antibiotic administration was 247 minutes (interquartile range 72 – 202 minutes). The mean age was 72 ± 15 years old and 122 patients (48.6%) were female. The most common site of infection was respiratory infection. The timing of antibiotic administration was not associated with 7-, 14-, and 28-day mortality. Female (adjusted hazard ratio [HR] 2.06 [95% confidence interval (CI) 1.21 – 3.53]; P value = 0.008), SOFA score (aHR 1.17 [95% CI 1.05 – 1.31]; P = 0.005), and initial lactate level (aHR 1.13 [95% CI 1.05 – 1.22]; P = 0.001) increased the risk of 7-day mortality. Female (HR 2.07 [95% CI 1.48 – 2.89]; P < 0.001), Charlson comorbidity index (aHR 1.12 [95% CI 1.02 – 1.24]; P = 0.025), and initial lactate level (aHR 1.19 [95% CI 1.02 – 1.16]; P = 0.011) increased the risk of 14-day mortality. Female (aHR 1.95 [95% CI 1.50 – 2.54]; P = 0.001) increased the risk of 28-day mortality in patients with sepsis.

**Conclusion.** The timing of antibiotic administration did not increase the risk of mortality in the treatment of sepsis patients who visited ED. Rather, the SOFA score, lactate, female, and comorbidity increased the mortality associated with sepsis.

**Table 1. Characteristics of OPAT for Serious Bacterial Infections Managed in ID Physician Office Infusion Centers**

| Type of Bacterial Infection | No. of Pts | Age (mean years± SD) | OPAT Duration (mean ± SD) | Clinical Success (n, %) | Serious ADRs during OPAT (n, %) | Failures during OPAT (n, %) | Hospitalizations during OPAT (n, %) |
|-----------------------------|------------|----------------------|--------------------------|------------------------|-------------------------------|---------------------------|---------------------------------|
| Bacterial sterile abscess   | 751        | 72±13                | 12±2                     | 122 (84.6%)            | 4 (3.5%)                      | 9 (6.7%)                  | 8 (6.0%)                        |

**Table 2. Risk factors for 7-day mortality of patients with sepsis**

| Variable                  | Unadjusted HR | P value | Adjusted HR | P value |
|---------------------------|---------------|---------|-------------|---------|
| Male                      | 0.597         | 0.035   | 0.485       | 0.030   |
| Age                       | 1.02          | 0.081   | 1.01        | 0.881   |
| BCI                       | 1.08          | 0.255   | 1.04        | 0.295   |
| SOFA                      | 1.15          | 0.004   | 1.13        | 0.001   |
| Septic shock              | 1.38          | 0.573   | 1.38        | 0.573   |
| CrP                       | 0.984         | 0.306   | 0.984       | 0.306   |
| Pseudomonas               | 1.01          | 0.328   | 1.01        | 0.328   |
| Lactate                   | 1.14          | 0.001   | 1.13        | 0.001   |
| Ou lactate                | 1.34          | 0.001   | 1.34        | 0.001   |

Abbreviations: CI: Confidence Interval; SOFA: Sequential Organ Failure Assessment