

in 508 patients (12.3%) in the preintervention group and in 319 patients (12.6%) in the postintervention group. In individuals with penicillin allergy, cefazolin prescribing increased from 49.6% to 74.3% ( $P < .01$ ) and vancomycin prescribing decreased from 50.4% to 25.7% ( $P < .01$ ). The largest changes occurred in patients undergoing cardiac, spinal, neurological, and vascular procedures. For patients without penicillin allergy, prescribing remained unchanged. Overall, cefazolin prescribing increased from 92.0% to 95.0% ( $P < .01$ ), and the rate of vancomycin prescribing decreased from 8.0% to 5.0% ( $P < .01$ ) in procedures for which cefazolin was preferred. **Conclusions:** Following the suppression of EMR alerts for non-IgE-mediated allergies when ordering cephalosporins, penicillin prescribing rates of cefazolin for surgical infection prophylaxis improved significantly in procedures for which it was the preferred agent. Further research on infection rates and adverse events with these and other alternative agents are needed.

**Disclosures:** None

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#### Presentation Type:

Poster Presentation - Poster Presentation

**Subject Category:** Surveillance/Public Health

#### Assessment of carbapenem-resistant *Acinetobacter baumannii*-colonized patients: Which specimens produce the highest yield?

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**Background:** Carbapenem-resistant *Acinetobacter* (CRA) bacteria are an urgent public health threat. Accurate and timely testing of CRA is important for proper infection control practices to minimize spread. In 2017, the CDC estimated 8,500 CRA cases among hospitalized patients, 700 deaths, and \$281 million in attributable healthcare costs. Treatment options are extremely limited for carbapenem-resistant *Acinetobacter baumannii* (CRAB) infections, making CRAB a unique concern. Colonization screening is a valuable tool for containment but requires sampling of 4 body sites. Identifying a reliable specimen collection site for CRAB is important to inform public health recommendations as screening can cost healthcare facilities valuable time and resources. **Methods:** Results of all screening specimens of patients with at least 1 site positive for CRAB on a unique collection date were extracted from the Southeast Regional data of Antimicrobial Resistance Lab Network (SEARLN) data. Non-CRAB screening and screenings that did not yield at least 1 positive result on a single collection date were excluded. We also limited our data to include only the following screening sites, which have been validated by the Tennessee Department of Health's State Public Health Laboratory: axilla and groin, rectal, sputum, and wound. For each specimen source, we calculated the percentage of positive specimen among CRAB-colonized patients. Data were extracted and analyzed using SAS version 9.4 software. **Results:** The SEARLN data contained 594 CRAB screening specimens collected over 4 years, 2018 through 2021, and 486 of those specimens yielded CRAB. For CRAB-colonized patients screened in this study, wound specimens had the highest positivity rate at 93.4% (95% CI, 89.9%–96.9%) of samples culturing CRAB. Sputum followed at 87.7%, then axilla and groin at 77.6% and rectal at 59.7%. **Conclusions:** Wound specimens produced the highest proportion of positive cultures among CRAB-positive patients, making them the sample type with the highest prevalence in our study. For healthcare facilities with limited time and resources seeking to optimize their CRAB screening process, wound specimens may be the most reliable single site for detecting CRAB colonization in patients with an open wound. When a wound is not present, sputum may be a good alternative single-source collection site. More research should be conducted before CRAB screening recommendations are updated.

**Disclosures:** None

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#### Presentation Type:

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**Subject Category:** Surveillance/Public Health

#### *Candida auris* screening practices at healthcare facilities in the United States: A survey of the Emerging Infections Network

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**Background:** *Candida auris*, an emerging fungal pathogen, is frequently drug resistant and spreads rapidly in healthcare facilities. Screening to identify patients colonized with *C. auris* can prevent further spread by prompting aggressive infection prevention and control measures. The CDC recommends *C. auris* screening based on local epidemiological conditions, patient characteristics, and facility-level risk factors; such screening might help facilities in higher burden areas to mitigate transmission and those in lower-burden areas to detect new introductions before spread begins. To describe US screening practices and challenges, we surveyed a network of infection disease practitioners, comparing responses by local *C. auris* case burdens. **Methods:** In August 2022, we emailed a survey about *C. auris* screening practices to ~3,000 members of the IDSA Emerging Infection Network. We describe survey results, stratifying findings by whether the healthcare facility was in a region where *C. auris* is frequently identified (tier 3 facility) or not frequently identified (tier 2 facility), based on CDC assessment using existing multidrug-resistant organism containment guidance (<https://www.cdc.gov/hai/containment/guidelines.html>). **Results:** We received 253 responses (tier 3 facilities: 119, tier 2 facilities: 134); overall, 37% performed screening. Tier 3 facilities more frequently performed screening than tier 2 facilities (59% vs 17%). Among facilities that performed screening, tier 3 facilities, compared with tier 2 facilities, more frequently screened patients on admission (84% vs 55%) and used an in-house laboratory for testing (68% vs 29%), most often with culture-based methods. Tier 2 facilities more frequently screened patients already admitted in the facility (eg, in response to cases or as part of point-prevalence surveys) compared with tier 3 facilities (59% vs 49%). Among facilities performing screening, 72% had identified  $\geq 1$  case in the previous year (tier 3 facilities, 85%; tier 2 facilities, 33%). Barriers to screening included limited laboratory capacity, long testing turnaround times, and the perception that screening was not useful. **Conclusions:** Most facilities surveyed did not perform *C. auris* screening. However, most facilities that performed screening, including those in regions of higher and lower *C. auris* burden, detected cases during the previous year. Admission screening, which might help detect new introductions before spread begins, was uncommon in facilities in lower-burden areas. Improving ease of *C. auris* screening through access to in-house laboratory testing with rapid turnaround times might increase the adoption of *C. auris* screening by facilities, thereby increasing detection and preventing spread.

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#### Contact tracing using a real-time location system in a tertiary-care hospital in Singapore

Guan Yee Ng and Biau Chi Ong

**Background:** Densely populated metropolitan cities like Singapore are susceptible to emerging infectious disease (EID) outbreaks. Singapore's pandemic control measures include running biennial simulation exercises for all public hospitals on EID case management, in which a key assessment