

cited reason (ie, 95% of HCFs) was fewer patients receiving services. The most common IPC-related reason for disruption was diversion of resources to accommodate physical distancing measures (76%) followed by COVID-19 outbreaks among patients or staff (34%); staff shortages due to COVID-19 illness (25%) or perceived infection risk (19%); and lack of adequate personal protective equipment (20%). **Conclusions:** Most HCFs reported disruptions to EHS during the pandemic, including many that were related to IPC. Some disruptions may be mitigated by strengthening IPC infrastructure and practices, including protecting healthcare personnel to prevent staffing shortages.

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**Presentation Type:**

Poster Presentation - Poster Presentation

**Subject Category:** Long-Term Care

**Using a learning needs assessment to develop infection prevention training for certified nursing assistants**

Erin Garcia; Tisha Mitsunaga; Vikram Haridass; Brienne Martin; Neha Sardana; Lisa Franqui; Kiya Komaiko; Tracy Lanier and Erin Epon

**Background:** In 2021, the California Department of Public Health Healthcare-Associated Infections Program developed new infection prevention and control (IPC) training for skilled nursing facility (SNF) certified nursing assistants (CNAs), as part of the CDC Project Firstline. CNAs comprise approximately one-third of SNF healthcare personnel (HCP) nationwide; ~50,000 CNAs are employed in California SNFs. Despite making up a large proportion of direct care HCP, CNAs can frequently lack understanding of fundamental IPC practices, including hand hygiene and appropriate personal protective equipment use. We conducted a learning needs assessment for SNF can and leadership to understand and design our program to meet CNA IPC training needs and preferences. **Methods:** We distributed the learning needs assessment via SurveyMonkey in English and Spanish with questions regarding current IPC practices and challenges, as well as preferred training delivery methods and posttraining support. We leveraged partnerships with CNA-affiliated organizations to engage CNAs throughout California. **Results:** Of 193 respondents, 80 (41%) were CNAs and 113 (59%) were leadership staff, representing 97 SNFs in 41 local health jurisdictions. Among CNAs, 34 (43%) believed that they had to do workarounds in their IPC practice and 18 (23%) stated that they would benefit from one-on-one question-and-answer sessions with an infection prevention expert. Also, 50 (63%) selected visual learning, 34 selected (43%) in-person learning, and 30 (38%) selected live or online trainings as their preferred learning style and training method. Most CNAs stated that they were most comfortable listening and speaking (73%) and reading (76%) in English only, followed by listening and speaking (16%) and reading (13%) in English and Spanish. For posttraining support, CNAs preferred access to online training materials (75%), digital materials (68%), virtual office hours with IPC educators (53%), and regular webinars (49%). **Conclusions:** The results of our learning needs assessment confirm the need for accessible IPC training and materials and continued engagement with posttraining support for CNAs. We will continue to provide online training and resources, access to IPC experts including an ‘AskBox’ for CNAs to e-mail IPC questions or request one-on-one support, and monthly office hours. Even though most CNAs are comfortable with training in English only, we will translate curricula into Spanish to support our bilingual Spanish-speaking CNA population. We are developing a tool kit to support SNFs and local health jurisdictions interested in providing their own training using our materials, and we will offer in-person CNA training. We will use our experience from this process in future learning needs assessments to inform other frontline HCP training, including for SNF environmental services staff.

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**Subject Category:** Long-Term Care

**Long-term care facility employee infection prevention adherence and prevention of COVID-19 outbreaks in a high-incidence area**

Jennifer Cihlar; Karen Volpe; Morgan Johnson; Claudio Mosse; Christianne Roumie; Todd Hulgand and Milner Staub

**Background:** Long-term care facility (LTCF) employees pose potential risk for COVID-19 outbreaks. Association between employee infection prevention (IP) adherence with facility COVID-19 outbreaks remains a knowledge gap. **Methods:** From April through December 2020, prior to COVID-19 vaccination, we tested asymptomatic Veterans’ Affairs (VA) community living center (CLC) residents twice weekly and employees monthly, which increased to weekly with known exposure, for SARS-CoV-2 via nasopharyngeal PCR. Employees voluntarily completed multiple choice questionnaires assessing self-reported IP adherence at and outside work. **Methods:** From April through December 2020, prior to COVID-19 vaccination, we tested asymptomatic Veterans’ Affairs (VA) community living center (CLC) residents twice weekly and employees monthly, which increased to weekly with known exposure, for SARS-CoV-2 via nasopharyngeal PCR. Employees voluntarily completed multiple choice questionnaires assessing self-reported IP adherence at and outside work. **Results:** Between April and December 2020, 444 employees completed at least 1 survey; 177 completed surveys in both April and June, 179 completed surveys in both June and July, and 140 completed surveys in both July and October (Fig. 1). Across periods, employee surveys demonstrated an increase in masking at work and outside work between April and June (63% to 95% [ $P < .01$ ] and 36% to 63% [ $P < .01$ ], respectively), and June to July (95% to 99% [ $P < .05$ ] and 71% to 84% [ $P < .01$ ], respectively) that were both maintained between July and October (Fig. 2). Distancing at work and limiting social contacts outside work significantly decreased from April to June but increased in subsequent periods, although not significantly. COVID-19 community incidence peaked in July and again in December, but CLC resident COVID-19 cases peaked in August, declined, and remained low through December (Fig. 3). **Discussion:** Wearing a mask at work, which was mandatory, increased, and voluntary employee masking outside work also increased. CLC COVID-19 cases mirrored community increases in July and August; however, community cases increased again later in 2020 while CLC cases remained low. Employees reporting distancing at work and limiting social contacts outside work decreased preceding the initial rise in CLC cases but increased and remained high after July. **Conclusions:** These data from the

	Matched Surveys 1 & 2	Matched Surveys 2 & 3	Matched Surveys 3 & 4
Female	131/179 (73.2%)	112/159 (70.4%)	76/118 (64.4%)
Age			
18-30	27/178 (15.2%)	21/181 (11.6%)	12/136 (8.8%)
31-40	29/178 (16.3%)	23/181 (12.7%)	21/136 (15.4%)
41-50	46/178 (25.8%)	52/181 (28.7%)	36/136 (26.5%)
51-60	60/178 (33.7%)	62/181 (34.3%)	51/136 (37.5%)
61-70	15/178 (8.4%)	23/181 (12.7%)	15/136 (11.0%)
71-80	1/178 (0.6%)	0	1/136 (0.7%)
81-89	0	0	0
90+	0	0	0
Sick contact within 30 days since prior survey	10	44	32
Reported travel outside state in last 30 days	22	34	34
Reported attending large gathering (>50 people) in last 30 days	16	28	20

Figure 1: Demographics of Paired Responders by Survey Period

Female and Age were calculated as the number (%) of all employees who responded to both surveys in the given period. For reported sick contact, travel outside the state and attending large gatherings, the total number of affirmative responses were summed for both surveys in the given period. Therefore, employees who answered in the affirmative on both surveys in the given period for any of those categories were counted as two separate responses.