

Table 2. Clinical characteristics of one site cohort

Clinical characteristics (%)	Positive SARS-CoV-2 Result (N=21)	Negative SARS-CoV-2 Result (N=452)
Contact Exposure*	85.7%	15.1%
More than 1 symptom	61.9%	67.7%
Fever or Cough or Loss of Taste or Smell	52.4%	62.8%
Runny Nose or Nasal Congestion	47.6%	58.6%
Fever	42.9%	33.0%
Cough	23.8%	40.7%**
Fatigue	38.1%	23.2%
Sore Throat	33.3%	19.5%
Headache	19.0%	13.0%**
Eye redness or discharge	14.3%	3.1%**
Diarrhea	9.5%	13.1%
Chills	4.8%	6.6%**
Loss of taste or smell	4.8%	1.8%**
Muscle Aches	4.8%	6.7%**
Nausea or Vomiting	4.8%	8.4%
Abdominal Pain	4.8%	10.7%**
Rash	0.0%	4.3%**
Shortness of Breath	0.0%	0.9%
Runny Nose or Nasal Congestion Only	9.5%	10.8%

* Chi-square test $p < 0.05$

**N < 452 due to use of a non-updated symptom screener form

nose presented in 10.8% of SARS-CoV-2–negative versus 9.5% of SARS-CoV-2–positive children. All children with isolated diarrhea ($n = 5$), isolated headache ($n = 3$), and isolated rash ($n = 2$) tested negative. Preliminary symptom data based on 176 children from a second site showed that 9.9% of symptomatic children had a positive test result. **Conclusions:** Runny nose or nasal congestion was the most frequently reported symptom in all children tested for SARS-CoV-2. However, isolated runny nose or nasal congestion identified 2 cases of COVID-19 in our cohort. Eye redness or discharge may be an important symptom to screen for COVID-19 in children. Further research with a larger number of positive cases is needed to make conclusions about improving efficiency and efficacy of symptom screeners for COVID-19 in children.

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Presentation Type:

Poster Presentation

Subject Category: COVID-19**Characteristics of Inpatients with False-Negative SARS-CoV-2 PCR Test Results**

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Background: At our institution, the concern for false-negative nasopharyngeal testing for SARS-CoV-2 at the onset of illness led to a general policy of retesting inpatients at 48 hours. For such patients, 2 negative SARS-CoV-2 PCR test results were required prior to discontinuation of COVID-19 control precautions. To assess the utility of routine repeat testing we analyzed patients presenting to our hospital who initially tested negative for SARS-CoV-2 but were found to be positive on repeated testing. **Methods:** All inpatients with symptoms concerning for COVID-19 were tested via nasopharyngeal sample for SARS-CoV-2 by PCR on admission. Patients with continued symptoms and no alternative diagnosis were retested 48 hours later. Testing was performed using either the Roche cobas SARS-CoV-2

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S56 2021;1 Suppl 1

RT-PCR assay or the Cepheid Xpert Xpress SARS-CoV-2 test. Between March 17, 2020, and May 10, 2020, we retrospectively analyzed data from patients with false-negative SARS-CoV-2 PCR test results who were subsequently confirmed positive 48 hours later. We evaluated demographic information, days since symptom onset, symptomatology, chest imaging, vital sign trends, and the overall clinical course of each patient. **Results:** During the study period, 14,683 tests were performed, almost half ($n = 7,124$) were performed through the ED and in the inpatient setting. Of 2,283 patients who tested positive for SARS-CoV-2, only 19 (0.01%) initially tested negative. Patients with initial false-negative test results presented with symptoms that ranged from fever and dyspnea to fatigue and vomiting. Notably, few patients presented “early” in their disease (median, 6 days; range, 0–10 days). However, patients with initial false-negative PCR test results did seem to have consistent imaging findings, specifically bilateral bibasilar ground glass opacities on chest radiograph or computed tomography scan. **Conclusions:** Among inpatients with COVID-19, we found a very low rate of initial false-negative SARS-CoV-2 PCR test results, which were not consistently related to premature testing. We also identified common radiographic findings among patients with initially false-negative test results, which could be useful in triaging patients who may merit retesting. Based on these data, we revised our existing clearance criteria to allow for single-test removal of COVID-19 precautions. Evaluating subsequent reduction in unnecessary testing is difficult given changing community prevalence, increased census, and increased opening to elective procedures. However, given the significant percentage of ED and inpatient testing, removal of repeated testing has likely resulted in a reduction of several thousand unnecessary COVID-19 tests monthly.

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Subject Category: COVID-19**COVID-19 Outbreak in an Acute-Care Hospital: Lessons Learned**

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Background: We describe the infection prevention investigation of a cluster of 15 healthcare workers (HCWs) and 7 patients in a single non-COVID-19 unit of an acute-care hospital in September 2020. **Methods:** The infection prevention team was notified of 13 SARS-CoV-2–positive, symptomatic HCWs in an acute-care non-COVID-19 unit in 1 week (August 30, 2020, to September 3, 2020). In the same week, 2 patients who had been on the unit were diagnosed with nosocomial COVID-19. An epidemiologic investigation identified the exposure period to be between August 19, 2020, and September 3, 2020. The following immediate containment measures were implemented: closing the unit to new admissions, restricting float staff, moving existing patients to private rooms, mandatory masking of patients, and mandatory respirator and eye protection on unit entry for all HCWs. Exposed unit staff were tested immediately and then every 4 days until September 18, 2020. Likewise, exposed patients, including those discharged, were notified and offered testing. Hospital-wide HCV surveillance testing was conducted. Enhanced environmental control measures were conducted, including terminal cleaning and ultraviolet C (UV-C) disinfection of common areas and patient rooms and a thorough investigation of airflow. Detailed staff interviews were performed to identify causes of transmission. Multiple town hall meetings were held for staff education and updates. **Results:** In total, 108 total patients were deemed exposed: 33 were inpatients and 75 had been discharged. Testing identified 5 additional patient cases among 57 patients who received testing; 51 chose to self-monitor for symptoms. Staff testing identified 2 additional cases. Thus, 15 HCWs and 7 patients were linked in this cluster. The containment measures successfully ended staff transmission as of September 5, 2020. The last patient case was detected on September 10, 2020. Secondary cases were noted in 6 HCW families. We identified staff