hospital activities, reduced the efficiency of patient care, and used medical resources. To address this problem, CH1 implemented a system of grouping inpatients to color-coded areas from June to December 2021. **Methods:** In this retrospective study, we describe the system of grouping inpatients to color-coded areas based on SARS-CoV-2 test result at a 1,600-bed, national pediatric hospital in Ho Chi Minh City. **Results:** Inpatients were first separated into those with or without respiratory symptoms, and secondly to different color-coded areas based on SARS-CoV-2 test result and hospitalization length: red zone (days 1–3), orange zone (days 3–7), and green zone (day 7 onward). Prior to admission, all patients were tested with a SARS-CoV-2 rapid diagnostic test. If negative, the patient was admitted to the red zone. On days 3 and 7 of hospitalization, the patient was tested using a pooled RT-PCR method. Patients negative on day 3 were relocated to the orange zone; patients negative on day 7 were relocated to the green zone. A patient with a positive test result at any time point was transferred to a COVID-19 zone. One caregiver was allowed to stay with 1 patient with similar testing regimen. A mobile transportation team was set up to deliver food and other necessities; thus, movement was restricted and interaction was prevented among zones. After this system was implemented, COVID-19 cases were detected early, with most positive cases in the red zone (19.6%) and the orange zone (2.8%), with only 1 case in the green zone (0.7%). **Conclusions:** The system of grouping patients to color-coded areas helped prevent SARS-CoV-2 transmission within the hospital, allowing undisrupted operation.

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Subject Category: COVID-19
Abstract Number: SG-APSIC1162
Challenges in building and running a 4,000-bed COVID-19 intensive care unit in an exhibition center
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Objectives: To describe the design process for a hospital in an exhibition center. We discuss challenges during the building process and areas in which risk assessments had to be made and practices modified to mitigate suboptimal conditions. **Methods:** UK National Health Service designers and military planners worked in conjunction with the infection prevention and control team (IPCT) to work with the existing infrastructure. The clinical area was deemed to be an aerosol-generating procedure (AGP) zone because it was entirely an intensive care unit. The challenges included no oxygen line, a lack of hot water, minimal access to cold water, almost no drainage, and a lack of physical space in which to carry out many necessary procedures. These challenges were overcome either by design or by changes to usual practices through mitigation measures. The IPCT had key roles in ensuring staff and patient safety and personal protective equipment (PPE) inventory management as well as donning and doffing procedures. **Results:** The Nightingale Hospital became a fully functioning ICU within 10 days of the build commencing, and the first patients were admitted within a few days. The hospital was used only sparingly because the national pandemic lockdown was in effect. In total, 72 patients were admitted, with a survival rate of 63%, comparable to established ICUs. Transmission rates of COVID-19 in staff were very low among those working clinically. The unit closed in June 2020 but reopened in January 2021 for rehabilitation with a smaller number of beds but better facilities as a result of our experience in the first iteration. **Conclusions:** A temporary hospital was built in an exhibition center to successfully manage a number of patients. Even in a temporary hospital facility that was limited in services, successful outcomes were achieved.

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Abstract Number: SG-APSIC1098
Impact of the COVID-19 pandemic on influenza vaccination uptake among healthcare workers
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Objectives: Influenza vaccination is encouraged for all healthcare workers (HCWs) to reduce the risk of acquiring the infection and onward transmission to colleagues and patients during the influenza season. Thus, vaccination was introduced at Singapore General Hospital (SGH) in 2007 and has been offered to all HCWs at no cost. The HCW influenza vaccination program is conducted annually in October and biannually during years with vaccine mismatch. However, influenza vaccine uptake remained low among HCWs. We sought to determine the impact of the coronavirus disease 2019 (COVID-19) pandemic on influenza vaccine uptake among HCWs. **Methods:** At SGH, 2 methods of vaccine delivery are offered: centralized (1-month drop-in system during office hours) and decentralized (administered by vaccination teams in offices or ward staff in inpatient locations). In the 4-year study period between 2018 and 2021, 6 influenza vaccination exercise campaigns were conducted during 8 influenza seasons. During each exercise, ~9,000 HCWs were eligible for vaccination. **Results:** Prior to the COVID-19 pandemic, vaccine uptake in the Southern Hemisphere was 77.6% (6,964 of 8,977) in 2018 and 84.2% (7,296 of 8,670) in 2019. During the COVID-19 pandemic in 2020, vaccine uptake in the Southern Hemisphere increased by 10% to 94.1% (8,361 of 8,889). In the Northern Hemisphere, vaccine uptake was 79.2% (7,114 of 8,977) in 2018, and this increased by 17.9% to 97.1% (8,926 of 9,194) during the COVID-19 pandemic in 2020. During the 2021 Southern Hemisphere influenza season, no vaccination program was conducted because the risk of influenza was considered low due to the closure of international borders and the implementation of public health measures. In addition, priority was given to COVID-19 vaccination efforts. **Conclusions:** Increased uptake of the influenza vaccination was observed during the COVID-19 pandemic. Anxiety created by the respiratory disease pandemic and debate surrounding vaccines likely contributed to increased awareness and uptake in influenza vaccine among HCWs.

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Healthcare-associated infections among the obstetrics and gynecology patients with confirmed COVID-19 in Hung Vuong Hospital, Vietnam
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