Location	Treatment (Clinical Infection)	No Treatment (Colonized)
Immunocompromised Floor	30 days from PCR+ regardless of whether patient receives treatment*	
All Other Floors	10 Days*	0 Days*

Figure 1. Duration of Contact Precautions for Patients with PCR+/Toxin- for *C. difficile*
*Patients must initially be placed on Contact precautions once PCR+ result notified to team with re-evaluation based on Toxin result and treatment decision

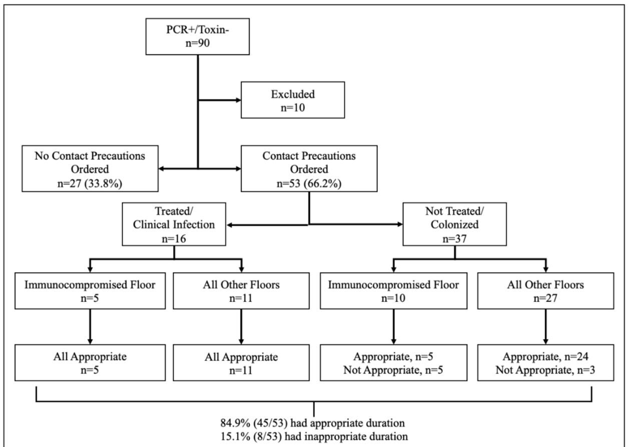

Figure 2. Contact Precaution Appropriateness by Type of Floor

Of patients who were placed on Contact precautions (n=53), 30.2% (16/53) were treated and deemed to have clinical infection, while 69.8% (37/53) were diagnosed with colonization and not treated for C. difficile infection. Overall, 84.9% (45/53) had appropriate de-escalation of Contact precautions; the remaining 8 (15.1%) had inappropriate de-escalation of Contact precautions and were all in the not treated/colonized group. **Conclusion:** In our single-institution study, we found higher than expected rates of appropriate Contact precaution initiation and discontinuation; however, 15% still had inappropriate precaution durations. Coupled with the surprising number of patients not initiated on precautions at any time after positive PCR, our results highlighted the need to build clear clinical decision support tools with our new EMR and continual surveillance of providers for adherence to isolation protocols post-implementation.

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Presentation Type:
Poster Presentation
Subject Category: Regulatory issues
Setting the Standard: Developing a High-Consequence Infectious Disease Preparedness Policy for a Comprehensive Cancer Hospital
Adina Feldman[1], Sherry Cantu[2], Rebecca Poths[3], Jane Powell[4], Guy Handley[5] and Amy Spallone[6]
[1]MD Anderson Cancer Center; [2]MD Anderson Cancer Center; [3]Univ of Texas MD Anderson Cancer Center; [4]MD Anderson Cancer Center; [5]MD Anderson Cancer Center and [6]MD Anderson Cancer Center

Background: In 2024, The Joint Commission (TJC) introduced Standard IC.07.01.01 to bolster hospitals' preparedness for high-consequence infectious diseases (HCIDs) such as novel Influenza, Ebola, and SARS-CoV-2. The standard emphasizes the need for an effective framework for managing emerging pathogens. While a definitive list of HCIDs does not exist, TJC defines HCIDs as, "novel or reemerging infectious agents characterized by high transmissibility, limited or no medical countermeasures, high mortality, and a need for rapid identification and stringent infection control." We outline the process of developing a policy at a National Cancer Institute-designated cancer center to ensure prompt and efficient management of suspected HCID cases. **Methods:** The policy development process began with a thorough review of existing hospital policies, infection control protocols, and environmental safety guidelines. Stakeholders from multiple departments including Environmental Health and Safety, Facilities Management, Employee Health and Campus police were consulted in the policy development process. A needs assessment was followed to identify gaps and areas requiring improvement. The policy was designed using key resources, including the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), and the National Emerging Special Pathogens Training and Education Center (NETEC). A framework based on the CDC's "Identify, Inform, and Isolate" model was employed, with tailored procedures addressing both clinical and operational aspects of preparedness and response. **Results:** The final policy grouped HCIDs into five categories: (1) Viral Hemorrhagic Fevers (VHF), (2) Novel Respiratory Viruses, (3) Measles, (4) Bioterrorism Agents, and (5) Other Emerging Pathogens. For each category, the policy delineated specific identification criteria, isolation protocols, and management procedures. It also provided guidance on engineering controls, visitor management, patient placement, environmental cleaning, and transportation. Additionally, the policy included external resources on clinical treatments and broader infection control issues. **Conclusion:** The development of an HCID policy in accordance with TJC Standard IC.07.01.01 provides a robust framework for hospital preparedness in managing high-consequence infectious diseases. By collaborating with Infection Control teams, healthcare institutions can develop protocols that enable swift, effective responses to emerging pathogens, ensuring adaptability during outbreaks. This policy not only facilitates TJC compliance but also enhances hospital readiness for future infectious disease threats. Moreover, it offers a replicable model that can assist other healthcare organizations in strengthening their emergency response capabilities and maintaining survey readiness in an evolving healthcare landscape.

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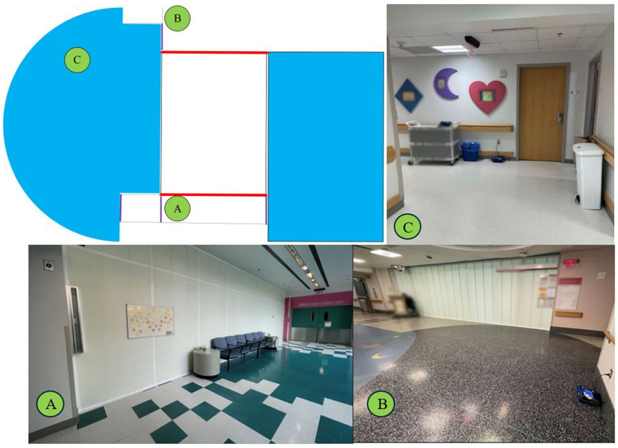
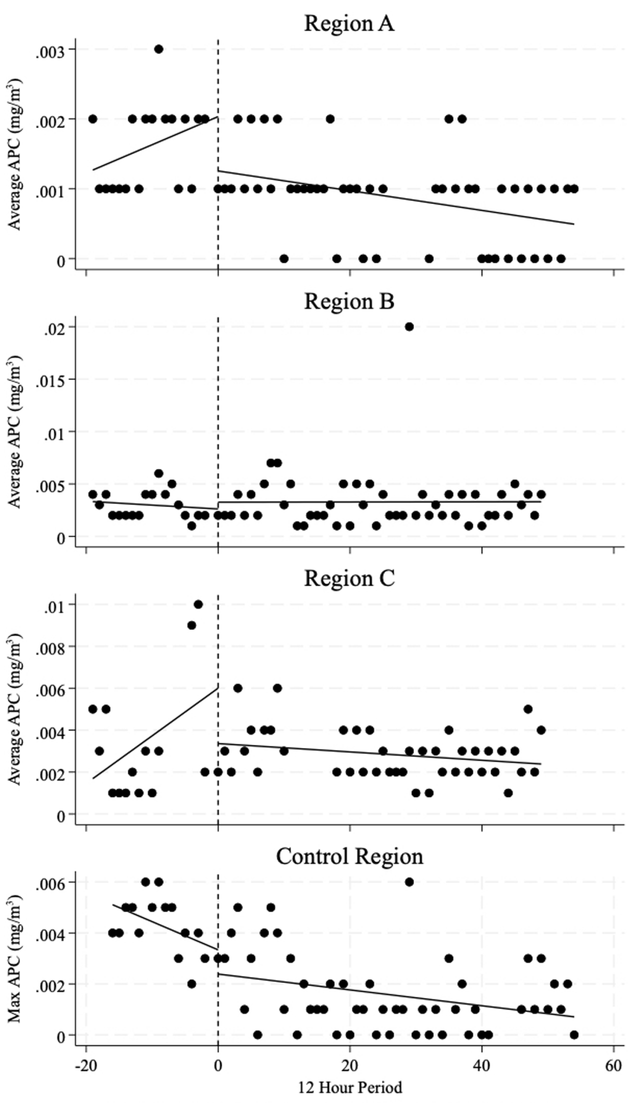
Presentation Type:
Poster Presentation
Subject Category: Research methodology and statistics
Will Walls Work: An Interrupted Time Series to Model Changes in Dust Burden After Architectural Changes
Nathan L'Etoile[1], Yun Li[2], Cody Gladstone[2], Cindy Hoegg[3], Amanda Scott[4], Ericka Hayes[4], Susan Coffin[5] and Logan Grimes[6]
[1]Children's Hospital of Philadelphia; [2]Children's Hospital of Philadelphia; [3]Children's Hospital of Philadelphia; [4]Univ Pennsylvania/Children's Hospital of Philadelphia; [5]Childrens Hospital of Philadelphia and [6]Children's Hospital of Philadelphia

Introduction: Dust burden in healthcare institutions has been associated with invasive fungal disease (IFD) causing significant morbidity and mortality in immunocompromised patients. Systematically evaluating the impacts of architectural changes on air particulate concentration (APC) could identify risk reduction strategies.
Objectives: We estimated changes in APC in units adjacent to a temporary hard physical barrier in a previously open hospital space after its erection. We propose a model for evaluating the impact of temporary architectural alterations on APC in healthcare settings. **Methods:** Barriers were erected in an open area of a hospital for four weeks. The barrier partitioned the oncology floor from the atrium, which houses the emergency department waiting area. Continuous APCs were measured in multiple locations before and after the barrier was erected. We conducted an interrupted time series on the daily mean and maximum APCs, excluding the period the barrier was being installed. As a control, the same analysis was conducted on a remote location of the hospital. **Results:** A topographical representation of the impacted area is included in Figure 1. Regions A and B are in hallways, adjacent to the barriers, and region C is in a patient care area, separated from the barriers by an automatic door. The control region was the cafeteria, which is separated from the barrier space by several hundred feet.





After barrier creation, there was an immediate APC reduction in region A from the predicted mean APC of 2μg/m3 to 1μg/m3 (difference of 0.8 μg/m3, p=0.01) (Figure 2). While the barrier was in place, there was a significant reduction in APC in region A by 0.01μg/m3 per day ($p < 0$ .001). There was no significant change in APC in regions B and C after the barrier was erected and while it was in place. In the control region, there was no significant change in APC at barrier placement nor afterwards. There was no change in the maximum APC at any of the measurement locations. **Discussion:** Our analysis demonstrated a change in APC at an adjacent area following erection of the barrier; however, APCs were not significantly changed in patient areas. This model could help objectively evaluate changes in particulate concentration. While this analysis cannot predict changes in IFD incidence, it could inform whether permanent architectural changes might reduce APC. **Conclusions:** We propose a model to evaluate changes in APCs from temporary architectural changes, which could inform permanent architectural changes.

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Presentation Type:
Poster Presentation
Subject Category: SSI
Surgical site infections among cesarean patients in Bangladeshi hospitals: results from an observational study

Shariful Amin Sumon[1], Aninda Rahman[2], Syed Abul Hassan Md Abdullah[3] and Md. Golam Dostogir Harun[4]
[1]icddr,b; [2]Communicable Disease Control, MOHFW; [3]South Asia Field Epidemiology & Technology Network (Safetynet) and [4]International Centre for Diarrhoeal Disease Research, Bangladesh (Icddr,b)

Background: Surgical site infections (SSIs) following cesarean deliveries (C-sections) result in excess morbidity, mortality, and healthcare expenses in resource-limited countries such as Bangladesh. Over the past two decades, C-section rates have increased dramatically in Bangladeshi hospitals, and comprehensive data on SSI after cesarean delivery, which is vital for the improvement of maternal health outcomes, remains limited. In this study, we assessed the prevalence of SSIs including their determinants among patients undergoing C-sections in Bangladesh. **Methods:** From May to December 2023, we conducted a prospective observational study at six tertiary hospitals (3 public and 3 private) in Bangladesh. Participants were hospitalized pregnant women who had undergone C-sections. The WHO-guided methodology and tools were employed to acquire the data. Participants were systematically evaluated on days 1-3, 7, 14, and 30 of surgeries, with a rigorous inquiry into symptoms such as fever, abdominal pain, localized swelling and redness, wound dehiscence, and purulence or abscess. The SSI diagnosis was confirmed based on at least two present symptoms, or a physician's assessment, or microbiological confirmation within the 30-day post-operative window. Descriptive and multivariate logistic analyses were performed to determine the prevalence and factors associated with SSI. **Results:** Of 1335 participants enrolled, the overall prevalence of SSIs was 19.1% (255/1335, 95%CI: 17.6-21.5), with public hospitals having almost twice as SSIs at 21.6% (215/995) compared to private hospitals (11.8%, 40/340). More than half of the patients (54.8%) were found with at least two SSI symptoms within the 7 to 14 days of follow-up. Approximately half of the patients (49.2%) had a history of previous C-sections. The C-sections performed in private hospitals were predominantly on an emergency basis (85.1%) compared to public hospitals (56.2%). The multivariate analysis identified key determinants of SSI following C-section were patients with prolonged labor > 18 hours (AOR: 2.2, 95%Cl: 1.16, 4.13), fetal distress (AOR: 1.82, 95%Cl: 1.33, 2.49), premature rupture of membrane (PROM) > 12 hours (AOR: 1.70, 95%Cl: 1.05, 2.75), and high BMI (AOR: 1.69, 95%Cl: 1.27, 2.25). **Conclusions:** This study highlights the burden of SSIs following C-sections in tertiary hospitals in Bangladesh, particularly in public healthcare settings. The findings highlight the critical need to enhance infection prevention and control measures to mitigate the occurance of SSIs within these healthcare settings.

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