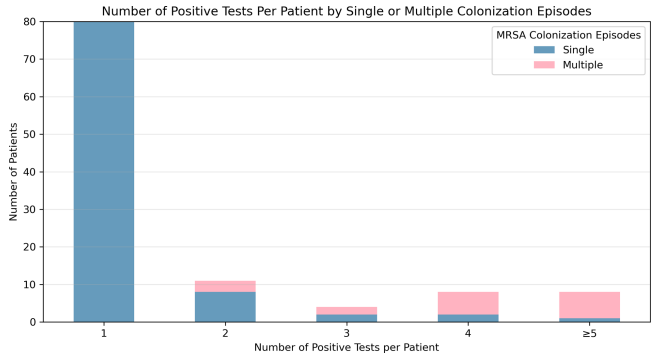
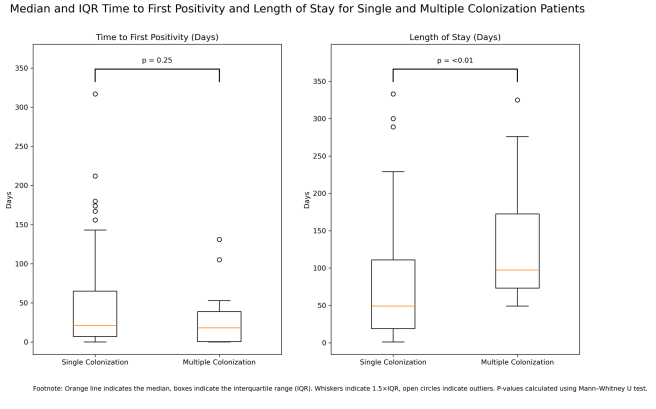




Healthcare Epidemiology in America recommends continuing contact isolation until NICU discharge, reflecting limited evidence to support safe discontinuation and recolonization concerns. We evaluated MRSA colonization dynamics in a NICU with an active surveillance program to better inform the evidence base for contact isolation practices. All patients in the 58-bed NICU at UCSF Benioff Children's Hospital San Francisco undergo weekly or biweekly MRSA culture screening. Colonized patients are placed in single-patient rooms on contact isolation for the duration of their NICU admission and undergo decolonization with intranasal mupirocin and topical mupirocin or chlorhexidine wipes; parents are also offered decolonization. We conducted a retrospective review of MRSA surveillance data from January 1, 2021 through December 31, 2024. A patient colonization episode was defined as one or more consecutive positive screens, with multiple episodes separated by at least one negative screen. Comparisons between patients with single and multiple colonization episodes were performed using the Mann-Whitney U test. Among 2,352 patients screened, 111 (5%) had at least one positive MRSA screen and of these, 80 (72%) had a single positive screen. The median time to first positivity (TFP) was 20 days (interquartile range [IQR]: 6-59) and the median length of stay (LOS) was 65 days (IQR: 24-134). Ninety-three (84%) patients had a single colonization episode and 18 (16%) had multiple colonization episodes (Figure 1). Compared with patients with one colonization episode, patients with multiple colonizations had similar median TFP (18 vs. 21 days; p=0.25), but a longer median LOS (98 vs. 49 days; p<0.01) (Figure 2). Colonized patients were placed on a cumulative 5,180 contact isolation days (median: 26 days per patient, IQR: 12-63 days); of these, 2,543 contact isolation days (49%) were during weeks with a negative screen. In a NICU with active MRSA surveillance, targeted decolonization, and robust horizontal infection prevention practices (e.g. hand hygiene, personal protective equipment, and environmental cleaning), MRSA colonization and recolonization detection was lower than previously reported in the literature. Despite this, contact isolation days accumulated substantially, with almost half of the days occurring during periods of negative surveillance testing. These findings highlight the need for further studies to assess MRSA recolonization risk and optimize the duration of contact isolation in NICU patients, ideally guided by local epidemiology and active surveillance.

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Subject Category: Pediatrics

Development and Implementation of "Isolation Precaution Stewardship Rounds": A Pilot Study in a Children's Hospital‡

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[1]Nationwide Children's Hospital - OSU and [2]Nationwide Children's Hospital

Background: Appropriate implementation of Transmission-Based Precautions (TBP) are necessary to decrease the risk of exposure to infectious pathogens and hospital-acquired infections (HAI). Through routine auditing, gaps were identified in the appropriateness of TBP orders within our institution. A multi-disciplinary quality improvement team was convened to implement a TBP stewardship pilot program with aim to increase TBP compliance and optimize use of personal protective equipment (PPE). **Methods:** Preintervention planning: A key-driver diagram (Figure 1) was created for the pilot program following multiple meetings with infectious diseases (ID) physicians, healthcare epidemiologists, infection preventionists (IP), and nursing leadership. Patients admitted to the ID ward and under the management of the ID service, consisting of 3 pediatrics residents, an ID Pharmacist, and the ID attending physician, were selected for the pilot program starting in October 2025. Protocol Design: Education materials were developed and distributed to members of the ID service, including nursing staff. The stewardship pilot program team, consisting of 4 IPs and 2 healthcare epidemiologists, conducted twice weekly chart reviews of ID ward patients to determine the appropriateness of TBP orders. The pilot program team would interface in-person to review the admitted patients with the ID service once weekly. To determine the impact of the pilot program, baseline and post-intervention TBP-appropriateness was compared using the chi-square test of proportions. **Results:** At baseline, 60% of patients were on appropriate TBP (n = 249). Following the implementation of the pilot program, the percentage of patients on appropriate TBP increased to 73% (n = 162), $p < 0.01$. During the interim analysis period, there were no noted outbreaks or documented HAIs on the ID ward. **Conclusion:** An interim analysis of the TBP stewardship pilot program demonstrated an improvement in the appropriateness of TBP applied to hospitalized patients. Based on qualitative comments from the physicians and nursing staff, the pilot program was well-received. Strengths of the program include real-time feedback, education, and review

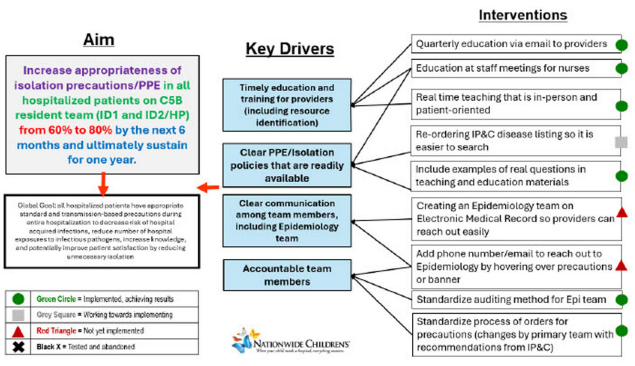


Figure 1: Key Driver Diagram. Global goal, aim, key drivers and interventions are included.
Abbreviations:
IP&C = infection prevention and control
Epi = epidemiology
C5B = infectious diseases unit
PPE = personal protective equipment
ID = infectious diseases
HP = hospital pediatrics

‡The abstract titles in this supplement have been corrected since original publication. A notice detailing the changes has been published at https://doi.org/10.1017/ash.2026.10802.

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as well as increased visibility of the Infection Prevention & Control team. Future efforts will focus on increasing TBP-appropriateness to the 80% goal and quantifying the impact on PPE utilization.

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Presentation Type:
Poster Presentation
Subject Category: Pediatrics

Shortening the Duration of Contact Isolation for Multidrug-Resistant Organisms in a Pediatric Hospital: A Quality Improvement Project‡

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[1]Ann & Robert H. Lurie Children's Hospital of Chicago; [2]Lurie Children's Hospital; [3]Ann & Robert H. Lurie Childrens Hospital of Chicago; [4]Lurie Childen's Chicago and [5]Lurie Children's Hospital of Chicago, Northwestern University

Background: Hospitalized patients colonized or infected with multidrug-resistant organisms (MRO) have historically been placed on contact precautions (CP) for months or indefinitely. However, the necessity of CP for

Table 1: MDRO de-isolation criteria

	Previous	Revised
Carbapenem-susceptible MDR GNR	• 6m isolation+ • Off directed antibiotics+ • Infection resolution+ • Negative culture from site	• Off directed antibiotics+ • Infection resolution
MRSA	• 3m isolation+ • Off directed antibiotics+ • Infection resolution+ • Negative culture from site • Negative MRSA swabx3	• Off directed antibiotics+ • Infection resolution
VRE	• 3m isolation • Off directed antibiotics+ • Infection resolution+ • Negative culture from site • Negative rectal swabx3	• 1m isolation • Off directed antibiotics+ • Infection resolution
CRE (non-carbapenamase producing)	• 6m isolation • Off directed antibiotics+ • Infection resolution+ • Negative culture from site	• 1m isolation • Off directed antibiotics+ • Infection resolution
CRE (carbapenamase-producing), C.auris, VISA, VRSA	• Indefinite isolation	• Indefinite isolation

Figure 3:

A.

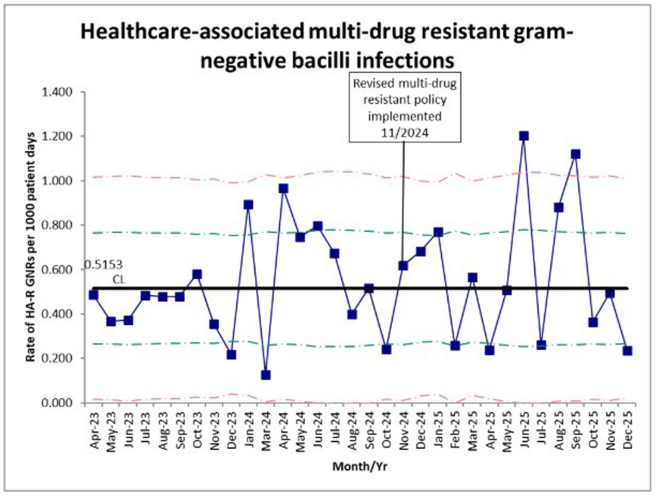


Figure 1:

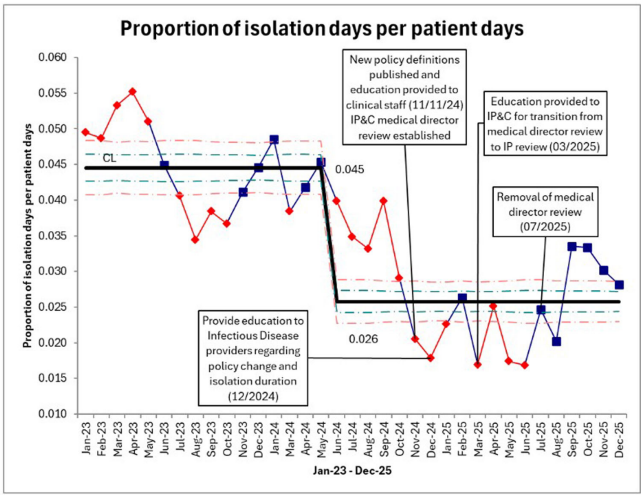
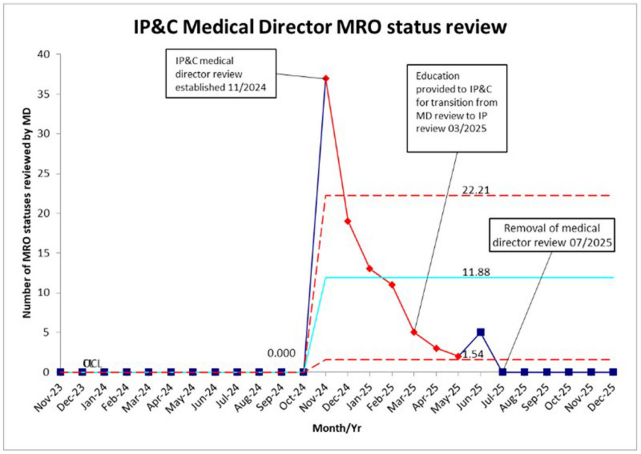
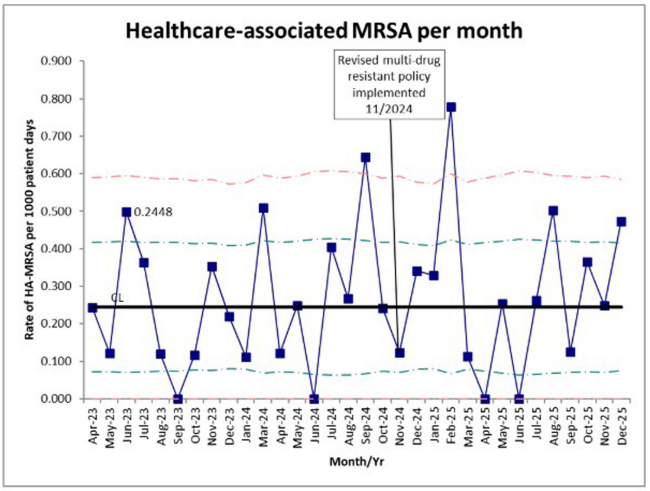


Figure 2:



B.



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