independent risk factor (OR 3.56; p **Conclusion:** CRAB acquisition in the EICU is primarily driven by carbapenem-associated selection pressure, invasive procedures involving fluid exposure, and colonization pressure. Notably, the lack of correlation between high hand hygiene compliance and acquisition rates suggests that individual-level efforts alone are insufficient to mitigate risk in high-pressure environments. Consequently, effective prevention requires a paradigm shift from individual compliance toward organizational strategies. This includes strengthening treatment-related infection prevention bundles for high-risk invasive procedures and implementing dynamic environmental controls based on real-time colonization pressure.

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Presentation Type:
Poster Presentation
Subject Category: MDR GNR
Optimized Swab-Based Skin Screening Improves Detection of Carbapenem-Resistant Acinetobacter baumannii‡
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Background: Active surveillance for carbapenem-resistant Acinetobacter baumannii (CRAB) is essential for infection prevention in endemic settings. Skin screening using pre-moistened sponges with enrichment has demonstrated the highest sensitivity for CRAB detection and is considered the reference standard. However, sponge-based sampling is labor-intensive and less feasible for routine use. Prior studies reported limited sensitivity of swab-based screening. We evaluated whether an optimized swab-based protocol, incorporating expanded skin sampling sites, could improve sensitivity compared with sponge sampling among known CRAB carriers. **Methods:** This paired-method study included hospitalized patients with documented prior CRAB carriage withing prior 3 months. On the day of screening, skin samples were collected before bathing simultaneously using Polywipe sponges and dry E-Swabs (Copan Italia S.P.A., Brescia, Italy), from opposite sides of the body. Swabs were used to sample multiple skin sites, including palm, interdigital spaces, antecubital fossa, axilla, groin, knee crease, sole of the foot, and toe webs, encompassing moist skin folds known to favor Acinetobacter colonization. Skin samples were collected from patients' arms and legs (groin and downward), Sponge samples were incubated overnight in brain–heart infusion (BHI) broth at 37 °C, vortexed, and plated onto CHROMagar MDR Acinetobacter. Swabs were broken directly into 3 mL BHI broth, incubated overnight, vortexed, and plated identically. Sponge sampling was defined as the gold standard. Sensitivity of swab screening was calculated among sponge-positive samples. **Results:** Among 134 paired screening samples from known CRAB carriers, 95 (70.9%) were positive by sponge sampling. Of these, 78 were also positive by swab screening, yielding a swab sensitivity of 82.1% (95% CI, 73.2–88.5). Thirty-nine patients (29.1% of the cohort) screened negative by both methods on the day of sampling, despite prior documented carriage. Discordant results were predominantly sponge-positive/swab-negative. **Conclusions:** Among patients with known CRAB carriage, an optimized swab-based skin screening protocol achieved substantially higher sensitivity than previously reported swab methods, though sensitivity remained lower than sponge-based screening. The inclusion of moist skin folds (such as the knee creases and toe webs), which are known to harbor Acinetobacter spp. but are not routinely sampled in previous studies, may explain the improved detection observed. The high proportion of negative screeing among known carriers highlights the dynamic and intermittent nature of CRAB skin colonization and the limitations of single time-point screening.

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Looking Behind to Move Forward: Evaluating Retrospective Chart Review in Contact Precaution Discontinuation Policies‡
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Background: Due to concern for ongoing colonization and substantial risks posed by horizontal transmission of RGN in acute care settings, it is common practice in many institutions to employ indefinite CP once a patient tests positive for resistant bacteria. However, it is important to recognize the adverse environmental and patient care costs of CP which has led institutions to consider structured CP discontinuation policies. Emerging evidence supports implementation of practices to safely discontinue CP in select patients following a defined period without subsequent positive cultures. Despite this, standardized methods to identify eligible patients remain unexplored. Objective: As a part of a larger study to evaluate our institution's adopted policy of contact precaution (CP) discontinuation for resistant gram negative organisms (RGNs) after one year of no subsequent positive cultures, we aimed to assess the utility of a retrospective audit of medical records as a strategy to identify patients eligible for CP discontinuation. **Methods:** A retrospective chart review of patients with identified RGNs in the Children's Hospital of Philadelphia (CHOP) electronic medical record (EMR) system from May 2021 to November. In concordance with the internal policy established November 202 recommending removal of contact precautions after one year without subsequent RGN culture positivity, each chart was assessed for the date and organism of the initial infection as well as last positive culture to determine eligibility for CP removal. Patients with carbapenem resistant organisms or those with cystic fibrosis were excluded from the review. **Results:** Of the/of the identified patients were determined to be eligible for de-labeling. The time required to determine eligibility status in the EMR was approximately 1 minute per patient totaling around 2.5 hours of review. **Conclusion:** This review identified a significant proportion of RGN-positive patients for whom standing CP were not removed in real time, allowing for an efficient update of CP status to align with hospital policy. Removal of CP not only alleviates a significant environmental and financial burden but also could contribute to a more positive patient/family experience during the hospital stay. The results of this study suggest that employing prospective plans for chart audits as CP discontinuation policies are modified would improve resource utilization.

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Factors Distinguishing Carbapenemase-producing Carbapenem-resistant Enterobacterales (CP-CRE) from non-CP-CRE‡
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Background: Within-hospital transmission has been reported with carbapenem-resistant Enterobacterales (CRE) infections. At our medical center, much of the CRE submitted for carbapenemase surveillance is non-carbapenemase producing (non-CP-CRE). We explored risk factors for CP-CRE vs non-CP-CRE infections in a cohort in our center in which both CP-CRE and CRE overall are rare to explore the hypothesis that horizontal transmission is more likely with CP-CRE. **Methods:** All patients with meropenem-resistant Enterobacterales isolated at MUSC March 2022 through February 2025 that were submitted to the state public health lab for modified carbapenem inactivation method (mCIM) testing and reflex

‡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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