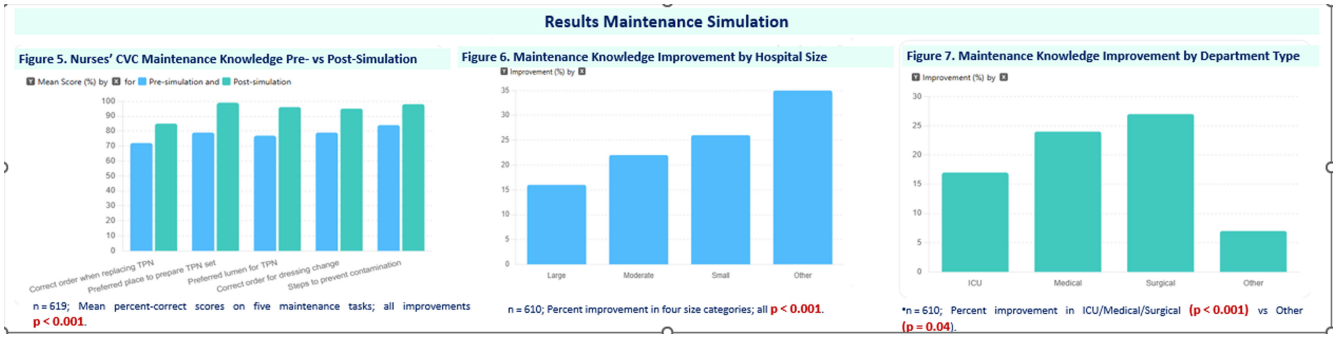


1,551 (91.2%) completed both pre- and post-training questionnaires. questionnaires assessed procedural knowledge, satisfaction, and availability of cvc-related equipment. knowledge outcomes were compared using paired t-tests, and associations between hospital characteristics, equipment availability, and knowledge improvement were evaluated using chi-square analyses. **Result:** knowledge scores improved significantly across all participant groups (p<0.001). mean knowledge gains were 18.6% for physician cvc insertion, 26.5% for nurse insertion, and 16.4% for nurse maintenance. the largest improvements were observed in sterile technique, minimal barrier precautions, and maintenance-related clinical decision-making. higher baseline knowledge was associated with icu settings, larger hospitals, and availability of full personal protective equipment (ppe) kits and disinfectant wipes (p<0.05). knowledge improvement was independently associated with refresher training, structured feedback during simulation, and access to full ppe kits, whereas hospital size and professional seniority were not consistently associated with learning gains. substantial variability in availability of essential cvc equipment was observed across departments. **Conclusion:** a nationally coordinated simulation-based training program significantly improved cvc insertion and maintenance knowledge among physicians and nurses across diverse hospital settings. structured feedback and reliable access to essential equipment emerged as key drivers of learning gains. these findings support simulation-based training as a scalable, policy-relevant strategy for strengthening clabsi prevention and standardizing practice at the national level, particularly in smaller hospitals and non-icu settings. background: central line–associated bloodstream infections (clabsis) remain a leading cause of preventable morbidity and mortality in hospitalized patients. although evidence-based guidelines for central venous catheter (cvc) insertion

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Poster Presentation
Subject Category: Implementation Science

Measles Post-exposure Investigations at a New York City Safety-net Hospital‡

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Background. Clinical identification of measles prompts post-exposure prophylaxis (PEP) and surveillance. This report informs on implementation, results, facilitators and challenges associated with two measles post-exposure investigations (MPEI). Methods. Two MPEI were conducted in 2025 at a 545-bed public NYC Health+Hospitals. Measles case evaluations utilized the Identify-Isolate-Inform (I3) tool and the MPEI employed Identify-Inform-Initiate PEP-Isolate process (I4). Measles exposure was defined as a person in the Emergency Department (ED) within two hours of the index case. PEP for non-immune exposures was MMR vaccination within 72 hours (immunocompetent), measles intravenous immunoglobulin (IVIG) within six days (pregnant, immunocompromised), or notification to self-isolate for a 21- to 28-day surveillance period for non-immune persons who did not receive PEP. The exposure window was defined after security tape reviews of ED index-case entries. Epic (Verona, WI) facilitated exposure recalls; a 'Measles rule out' banner was uploaded to each chart. Internal and external stakeholders were informed after suspected case isolation. Recalls were conducted using standardized scripts tailored to initial responses and identified accompanying persons. MMR vaccination status was screened for in Epic and NYC vaccine registry. Descriptive analyses were calculated for MPEI. Results. Case 1 presented in Spring 2025 with airborne infection isolation room (AIIR) placement within 16 minutes. Case 2 presented in Summer 2025 with AIIR placement within 10 minutes. Each case had measles serology and nasopharyngeal swab for PCR obtained; the NYC Public Health Laboratory confirmed measles for Case 1 and Case 2 at 28- and 11-hours post-presentation, respectively. There were 145 adults and one child identified in the two MPEI. Spring MPEI identified 70 patients, 11 accompanied persons, 34 staff; Summer MPEI identified 22 patients, three accompanied persons, six staff. Fifty-nine of 146 (40%) exposures were measles immune, 30 received MMR, 3 non-immune pregnant women and one immunocompromised host received measles IVIG; 53 persons were notified to self-isolate through the surveillance period. No secondary cases of measles were identified. Discussion. Each MPEI was initiated after astute identification of a measles case. Key MPEI facilitators were an existing I3 preparedness plan and prior trainings, rapidly defined epidemiological exposure windows, leveraged use of Epic, and a structured post-exposure I4 process. Major challenges were related to uncertainty of a potential surge of cases requiring internal communications for patient flow during the recall process and for streamlined bidirectional communication with public health agencies. We acknowledge limitations of a single-site study and inherent biases of retrospective study design.

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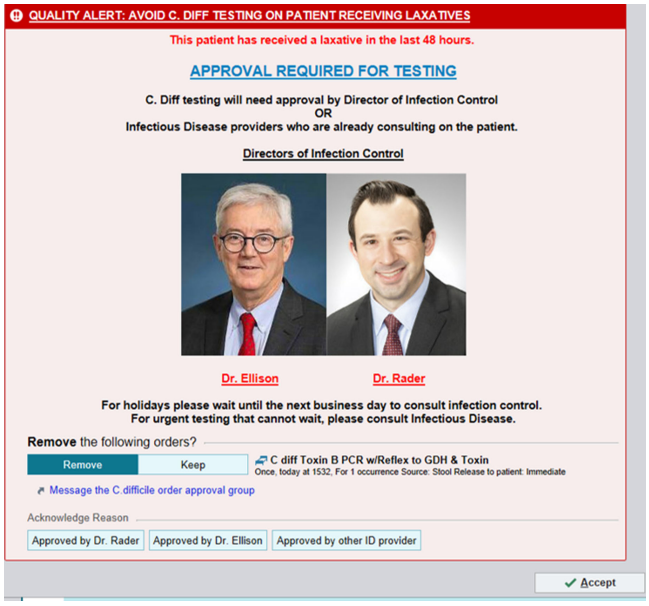
Putting a Face to Hard Stop C. difficile Testing Stewardship‡

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Background: Clostridioides difficile infection (CDI) is a leading cause of healthcare-associated infection in the United States. Diagnostic stewardship is a core element of reducing inappropriate CDI testing. **Methods:** In response to rising rates of hospital onset CDI (HO-CDI), our institution

‡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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implemented a "hard-stop" clinical practice alert (OPA) in the Electronic Medical Record (EMR) in July 2024, shown in Figure 1. The OPA fired when a CDI test was ordered on patients hospitalized greater than 48 hours who had received laxatives within the previous 48 hours or who had a positive test within the previous 7 days and was active from 7AM-5PM Monday through Friday. OPA completion to order CDI testing required approval from either the Infection Prevention & Control Medical Directors (IPCMD) or a consulting Infectious Disease (ID) physician if patient was followed by ID. To facilitate communication, a dedicated "chat group" was created in the EMR instant messaging to specifically respond to a request for testing by the IPCMDs and a link to the chat was included in the OPA. EMR documentation of the approving IPCMD was required, and logs were regularly reviewed for compliance. Every HO-CDI case at our institution undergoes a multidisciplinary review with the staff and primary providers involved in the care of the patient at time of diagnosis to identify a "driver" for the case. Testing Stewardship, defined as inappropriate testing due to noncompliance with institutional CDI testing guidance, is one of the 5 drivers that can be assigned during this review process. **Results:** Over the 12.5 months following implementation the OPA was triggered 432 times on 214 unique patients with testing performed 79 times (0.18 tests per trigger). Twenty of 79 tests (25%) were positive for toxigenic C. difficile. In the 12 months prior to the OPA, there were 17 of 88 HO-CDI cases attributed to Testing Stewardship compared to 4 of 58 in the 12 months after the OPA (18/80 vs 4/58 by fiscal year). In the context of multiple interventions, NHSN-defined HO-CDI declined from 68 in FY 2023, 80 in FY 2024 to 58 in FY2025, corresponding to rates of 2.22, 3.13 and 1.7 per 10,000 patient days, respectively. **Conclusion:** A multicomponent OPA requiring approval for CDI testing for specific parameters was successfully implemented. This intervention contributed to improved diagnostic stewardship and reduction on HO-CDC cases Figure 1: C. difficile Hard Stop OPA example for patient with recent laxative administration

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Subject Category: Infection Prevention in Low and Middle-Income Countries

Enhancing Capacity to Properly Perform Infection Prevention and Control Practices Through a Multimodal Approach to Building Knowledge‡

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Background: Effective implementation of infection prevention and control (IPC) reduces the risk of healthcare-associated infections (HAIs), thereby protecting patients and healthcare workers. Tanzania has experienced ongoing outbreaks demonstrating a need for stronger IPC. Amref Health Tanzania, in collaboration with the Ministry of Health and U.S. Centers for Disease Control and Prevention, implemented a multimodal project in Kigoma, a high HAI-risk region, aimed at improving IPC practices in 20 healthcare facilities (HCF). It involved activating Quality Improvement Teams (QIT), supportive supervisions and mentorships, quarterly standardized assessments using the national Standard Based Management and Recognition (SBMR) tool, and virtual and in-person trainings. We evaluated progress and effectiveness of the project. **Methods:** We conducted a mixed methods evaluation of the project in March 2024. Ten HCFs were selected purposively to have variation on location, IPC performance, and level and convenience sampling was used to select staff. A comparative cross-sectional design was utilized to collect data through focus group discussions (FGDs), key informant interviews (KIIs), and quantitative knowledge assessments and practice observations. A comparison of SBMR results at baseline (September 2021) and endline (October 2023) was completed to assess effectiveness of the project. Quantitative data were analyzed using STATA 14 software and thematic analysis was conducted for qualitative data. **Results:** Ten FGDs, 8 KIIs, 150 knowledge assessments, and 6-11 observations per HCF were conducted. The SBMR baseline to endline comparison showed IPC performance increased for 95% of HCFs, from 49.9% to 70.7%, on average. During knowledge assessments participants verbally described accurate knowledge of IPC practices 28.0% of the time, with a higher proportion of participants from rural districts (40.8%) and medical doctors (55.6%) describing practices accurately. Based on observations, adherence to injection safety and high-level disinfection was high; weaknesses were observed for hand hygiene, waste management and spillage cleaning. Thematic analysis of qualitative data revealed strengths in the frequency of supervisions and SBMR assessments. Remaining challenges include insufficient infrastructure, supplies, and HCW IPC knowledge on implementation of IPC practices, such as hand hygiene. **Conclusion:** Although the comparison of baseline and endline SBMR results show progress, IPC knowledge and adherence to evidence-based practices remain low three years into the IPC project, further hindered by insufficient infrastructure and

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