that included didactic sessions and sharing of data provided ongoing mentorship and feedback on quality improvement implementation, data interpretation, and data use. **Results:** Hand hygiene data collection began in April 2018. In hospital A, hand hygiene compliance increased from a baseline of 3% to 51% over 9 months. In Hospital B, hand hygiene compliance rates increased from 23% at baseline to 44% after 9 months. Waste management data collection began in November 2018. At hospital A, waste segregation compliance scores increased from 73% at baseline to 80% over 6 months, whereas hospital B, waste segregation compliance went from 44% to 80% over 6 months. **Conclusions:** A quality improvement approach appears to be a feasible means of infection prevention and control program strengthening in low resource settings.

Presentation Type:
Poster Presentation
Improving Appropriate Testing for *Clostridium difficile* Infection: Update on Sustainability of a Quality Improvement Project

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Background: Children aged <1 year are usually colonized with *Clostridium difficile*: colonization rates range between 30% and 70%. In children, other infectious causes of diarrhea are more common than *C. difficile.* Molecular testing for *C. difficile* yields very high sensitivity. Clinical judgement is required for testing children with suspected infectious diarrhea. Inappropriate *C. difficile* testing may lead to antibiotic overuse. **Methods:** Initially, for the years 2016–2018, we collected data for positive *C. difficile* nucleic acid amplification tests (NAATs) at Sanford Children's Hospital. In 2017, a physician-driven protocol was implemented to replace the current nurse-driven protocol for testing. We implemented national guidelines for testing and treatment in pediatric patients. Microbiology lab was given autonomy to use Bristol stool criteria to process stool samples for *C. difficile.* Formed stools were rejected for testing for *C. difficile.* The result was suppressed in patients aged <1 year. We presented the available data at the SHEA spring conference in 2020. We collected new data until June of 2019 to measure the sustainability of the intervention. **Results:** In 2016, there were 78 *C. difficile* tests: 17 were positive and 11 were categorized as an HAI. From January 1 to June 30, 2017, there were 26 *C. difficile* tests: 8 were positive and 3 were categorized as an HAI. Furthermore, 16 *C. difficile* tests were obtained from July 7 to December 31, 2017: 4 were positive and 1 categorized as an HAI. In 2018, there were 18 tests and 2 were positive; 1 was categorized as an HAI. In 2019, there were 16 tests and 2 were positive; 1 of these was categorized as an HAI. **Conclusions:** Implementing 2 interventions (removal of a nurse-driven protocol and microbiology lab autonomy for rejecting formed stool samples) for improving *C. difficile* testing accomplished a reduction of >80% in the number of tests obtained. Overall, there was a sustained reduction in the number of positive tests and HAIs in the years 2018 and 2019. The 2 interventions have been sustainable over time.

Presentation Type:
Poster Presentation
Improving Confirmatory Testing for the Antimicrobial Resistance Surveillance Network in Ethiopia

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Table 1: Gaps and solutions

Gaps	Solutions
Sites required to submit all priority AMR isolates for confirmation. NRL tested 10%; retained all isolates indefinitely.	Selection algorithm developed that limits submissions to 12 isolates/month/site; Isolates discarded after 2 months.
Sites did not retain original isolates or work cards; were unable to retest discordant results.	Aliquot and work card retention required for up to 2 months.
Difficult to interpret result forms.	Isolate Submission and Results Form simplifies results comparison, error visualization, and captures additional data for troubleshooting and M&E.
Discordant results were not retested by the NRL, leading to mistrust from sites.	Discordant results require repeat testing by an alternate method.
Absence of scoring system.	Excel Scoring Matrix calculates scores for each isolate and each month. Errors classified by type, weighted by severity.
Site performance not monitored over time.	Excel Scoring Matrix graphs monthly scores and error rates. Biannual evaluation by NRL required.
Sites reported delays receiving results from the NRL.	One month turn-around time (TAT) required; monitored via Excel spreadsheet.
Root-cause analysis (RCA) and corrective action (CA) performed infrequently and inefficiently.	RCA/CA Checklist provides systematic guidance; requires sites submit RCA/CA to NRL for each discordant result within one month.