

rooms without proper isolation. Also, one and four healthcare personnel were diagnosed with pulmonary tuberculosis in 2018 and 2019, respectively. Additionally, the treatment success rates for pulmonary tuberculosis patients were 74.63% and 79.92%, respectively (target >85%). Therefore, to achieve these target goals, actions were taken following the national tuberculosis strategy using the FCD Nan model, which comprises of Fast screening (F), Cure (C), and do not spread (D). **Objectives:** To develop the tuberculosis patient-care system at Nan Hospital and assess the outcomes of the tuberculosis patient-care system in terms of FCD Nan model **Methods:** We used the PDSA quality improvement process as follows.

1. Plan: Planning to implement the national tuberculosis strategy including fast screening, cure, and prevention of transmission.
2. Do: Implementing the FCD Nan model as follows.
  - 1) Fast screening. We used a fast-track system, enhanced screening efficiency in both OPD and IPD units, established a Line group alert pop-up and AI CXR.
  - 2) Cure. We adhered to treatment protocols, closely monitored cases, consulted specialists, utilized risk scoring for mortality, and nutritional alert.
  - 3) Do not spread. We administered 3 measures for preventing transmission including administrative, environmental, and PPE measures.
3. Study: Evaluating the FCD Nan model.
4. Action: Identifying household contacts as a high-risk group and implementing screening for all household contacts due to the discovery of new tuberculosis patients in the household contacts.

**Results:** 1) Screening rates increased from 81.8% to 93.07% for OPD and from 70.76% to 97.29% for IPD. 2) Cure: Treatment success rate increased from 89.81% to 91.43% Do not spread: and 3) No incidence of tuberculosis among healthcare personnel. **Conclusion:** The FCD Nan model using the national tuberculosis strategy of fast screening, cure, and do not spread can be used to achieve the goals of tuberculosis control.

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**Batik marker as an implementation of prevention of contact transmission of MDRO patients**

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**Background:** WHO estimates over 700,000 deaths globally annually due to antimicrobial resistance. One of the main factors of antimicrobial resistance is non-compliance with infection control measures. Contact alert markers must be installed in the patient area to remind officers to carry out infection transmission prevention to prevent the failure of infection control practices. The provision of red markers and information on the infection suffered by patients creates a stigma that is less accepted because of patient privacy. This study aimed to evaluate the modified marker with a batik design as local wisdom without infection information, as a reminder of infection control practices by officers, and to maintain patient privacy. **Method:** The Committee for Infection Prevention and Control modified the design of markers of patients with antimicrobial resistance. Batik markers were designed with hand hygiene reminders and batik motifs as local wisdom so as not to cause negative stigma. Batik markers were implemented in the patient's bed area so that it was easy for officers to

understand how to implement infection control practices and supervise patients with antimicrobial resistance. **Results:** Modifying the marker design was more acceptable to the patient's family than the previous one. Adherence to supervision filling of antimicrobial resistance patients was performed in all patients. Adherence to Hand Hygiene increased by up to 4% in one month. With the Batik Marker, officers could easily recognize the marker so that infection control practices could be carried out according to hospital regulations. **Conclusion:** Antimicrobial resistance is an increasing health threat. A type A hospital requires an intradisciplinary approach and collaborative efforts to prevent and control it. Implementing Batik Markers at inpatient areas with antimicrobial resistance makes it easier for staff to implement increased contact awareness, supervision recording, and improved hand hygiene without causing rejection from the patient's family.

**Keywords:** Antimicrobial Resistance Patient Marker; Hand Hygiene; Infection Control Practices; Antimicrobial Resistance Patient Supervision  
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**Geriatric patients with multidrug resistant organisms in sepsis with community acquired pneumonia, pedic diabeticulcer, decubitus ulcer stage III, diabetic kidney disease stage V, urinary tract infection and anemia : case report**

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**Introduction:** Patients with MDRO infection at hospital admission had increased the length of treatment. MDRO infection is also one of the factors that causes death in hospital. **Case Presentation:** A 68 year old man. Hospitalized with decreased consciousness. Experienced severe shortness of breath 3 days before entering the hospital. The patient also had wounds on his right and left legs since 1 month ago. But then became more widespread. The patient has kidney failure and routinely undergoes hemodialysis. The patient had diabetes since 6 years ago. Laboratory: Hemoglobin 7.5 Leukocytes 17.8 Neutrophils 91.70 Lymphocytes 4.20 Albumin 2.2 Creatinine 2.5 Urea 61 Artery 2.30, urine bacteria+++ . Pus culture results: Enterobacter cloacae with the antibiotic meropenem. Sputum culture results Klebsiella pneumoniae ss. Pneumoniae with amikacin. After 1 week pus culture results: Pseudomonas aeruginosa with amikacin. Blood



**Figure :** Diabetic ulcers and decubitus ulcers in patient