

complex were excluded. A positive case is TB PCR or culture positive. Harm is defined as PTB exposure due to premature discontinuation of isolation. The algorithm recommended clinicians to collect a single induced sputum for low/moderate-risk patients with additional testing reserved for high-risk cases. **Results:** A total of 1,152 samples were collected from 747 patients; 513 expectorated sputa (44%), 194 induced sputa (16.8%), 445 bronchoscopies (38.6%). The median isolation duration was 6 days and the turnaround time for results ranged from 3–11 days. The positivity rate was 0.2% for performing expectorated sputum first (1/513), 2.5% for performing induced sputum (3/118) first, and 1.8% for BAL performed first (3/169). When comparing repeated induced sputum testing, all the samples were positive from the first specimen (Figure 2). **Conclusion:** These findings illustrate the real-world implications of using a single induced sputum to rule out PTB in low/moderate pre-testing probability patients, potentially leading to the reduction in airborne isolation days. No added harm via patient exposures was detected with the use of this algorithm.

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Measures implemented to reduce Blood Culture Contamination in Intensive Care Units at a Veteran's Administration Hospital

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Background: Blood Culture Contamination (BCC) is a significant safety and quality indicator for intensive care units (ICU) at the Veteran Affairs North Texas Healthcare System. In February 2023, the combined ICU BCC rate was 4.7%. The American Society for Microbiology and the Clinical Laboratory Standards Institute recommends a BCC rate not exceed 3%. **Methods:** In March 2023, a multidisciplinary workgroup was created to reduce the combined ICU BCC rate to a target goal of evidence-based standardized process was implemented using a blood culture kit and guide, hand hygiene, site prep, and aseptic technique. Nurses were also educated to avoid drawing from existing lines. In phase two, a second verifier was added to observe blood culture draws, and documentation fields were modified to record the verifier's name and location. Training reinforced hand hygiene, use of clean gloves, site prep, and cleaning bottle tops with alcohol. In addition, the Microbiology supervisor disseminated monthly BCC reports to key stakeholders. BCC Champions used reports to monitor compliance with processes, and if deficits were detected, feedback was provided to nurses for immediate corrective action. **Results:** In the 6-month pre-intervention period (12/1/22 – 3/31/23), 16 BCC events occurred from 570 blood cultures, 2.7% BCC rate. In the 6-month intervention period (4/1/23 – 9/30/23), 16 BCC events occurred from 548 blood cultures collected, 3.1% BCC rate (Phase 1: 2.2% BCC rate, Phase 2, 3.5% BCC rate). The BCC rate reduced by 60% from a peak of 4.7% in the pre-intervention period (2/23) to 1.9% (9/23). In May 2024, a new blood culture kit was piloted and adopted for use in the ICU. Quarterly workgroup meetings were implemented to monitor the quality initiative. In the 12-months post-intervention (10/23 – 9/24), the ICU BCC rate was 1.9%. **Conclusion:** We reduced the ICU BCC rate to Reducing BCC may lower healthcare costs and reduce unnecessary antibiotic use.

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Figure 1 Combined Intensive Care Units (ICU)¹ Blood Culture Contamination Rates, October 2022-September 2024.

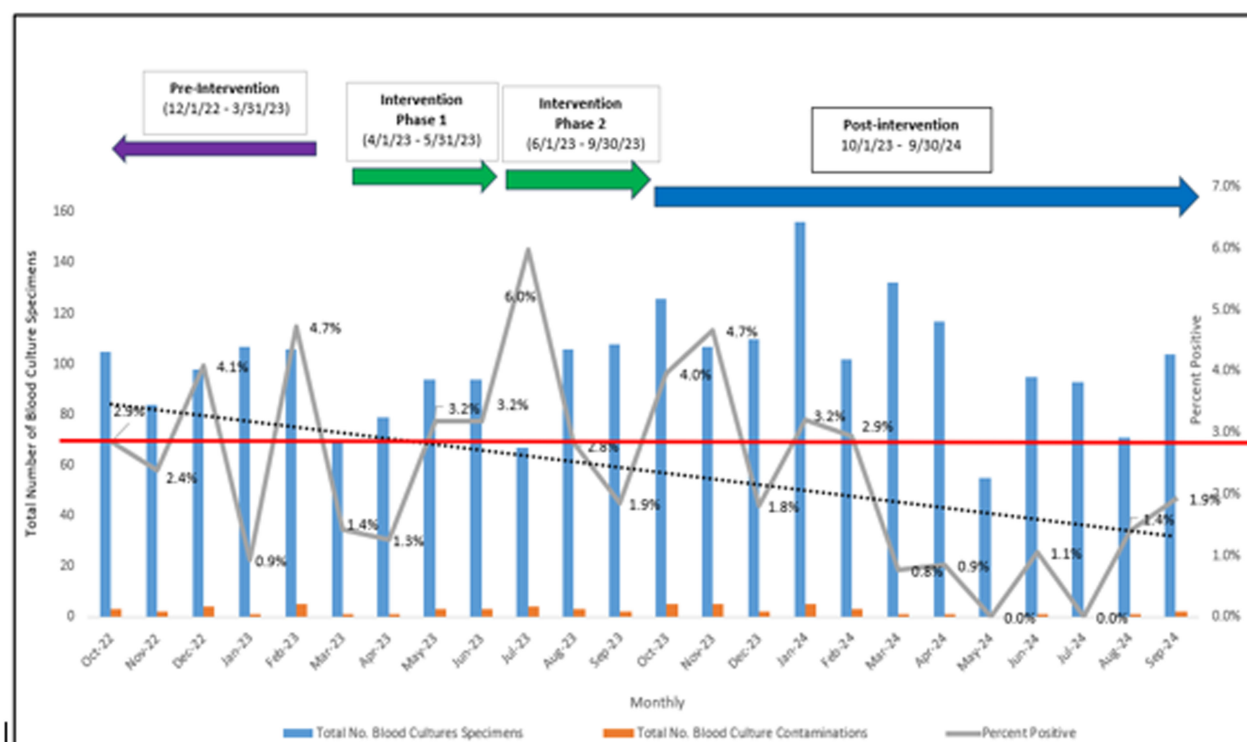


Figure 1. Combined Intensive Care Units (ICU)¹ Blood Culture Contamination Rates, October 2022-September 2024.

The combined ICU includes the medical intensive care unit, critical intensive care unit, surgical intensive care unit, and thoracic intensive care unit. The red line indicates the national benchmark of 3%. The grey line represents the combined ICU monthly BCC positivity rate. The black dashed line shows the data trend.

Presentation Type:

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Candida auris and Carbapenemase-Producing Organisms Travel

Screening: Program Implementation and Initial Report

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Background: *Candida auris* (C. auris) and carbapenemase-producing organisms (CPOs) are rapidly emergent healthcare-associated infections (HAIs) with high mortality. Early identification and isolation of colonized patients are crucial in preventing spread. Currently in Oregon, both organism types are uncommonly encountered such that local public health guidance advises travel-related screening as an important component of regional prevention. In 2024, VA Portland Health Care System (VAPORHCS) implemented a C. auris/CPO travel screening program as a quality improvement project. **Methods:** Using the Plan-Do-Study-Act (PDSA) framework, starting 4/1/2024 patients admitted to acute care were asked, "Have you had an overnight stay in a hospital, nursing home, or other healthcare facility outside of Oregon or Washington in the last year?" If patients responded affirmatively, the admitting nurse educated the patient and collected swabs after verbal consent: axilla/groin swabs

for C. auris and peri-rectal swabs for CPOs. Patients were placed on empiric contact precautions in a single-bed room while awaiting results. Infection prevention prospectively monitored the implementation, and retrospectively medical records were reviewed. **Results:** The PDSA framework informed the implementation and helped organize the approach to addressing barriers such as missed screenings, communication breakdowns, complex disinfection protocols, the need for staff re-education, and delayed C. auris results (see Figure).

Of 3199 acute care admissions between 4/1/24–11/30/24, 72 patients (2.3%) reported a qualifying travel-related risk factor. 64 patients reported overnight healthcare elsewhere in the United States and Territories (including 5 in Puerto Rico) whilst 8 patients had international exposure (Mexico n=6, Philippines n=2). Of the 72 patients with qualifying travel, 9 patients were not tested (patient refused n=2, staff deemed inappropriate n=3, readmission n=1, unknown/technical issues n=3). An additional 32 patients (1%) initially reported qualifying travel but on chart review, travel was not confirmed. Of those, 16 had testing performed, all of which were negative. The average C. auris test turnaround time was 7.7 days with a range from 3-18 days. One patient (2.4%) tested positive for CPO. **Conclusion:** The C. auris/CPO screening program was effectively implemented and identified one positive CPO case, preventing the need for an urgent outbreak investigation. The PDSA framework helped the