

Relationship between MRSA HAC and HCAHPS question

Response to HCAHPS Question 8: "During this hospital stay, how often were your room and bathroom kept clean?"	n	Mean	SD	Skewness Statistic	Spearman rho correlation	p-value
Always	1725	67.47	6.19	-0.316	-0.141	<0.001*
Usually	1725	20.66	2.88	-0.037	0.066	0.006*
Never	1725	11.87	4.18	0.830	0.175	<0.001*

\*p <0.05

Relationship between CDI HAC and HCAHPS question

Response to HCAHPS Question 8: "During this hospital stay, how often were your room and bathroom kept clean?"	n	Mean	SD	Skewness Statistic	Spearman rho correlation	p-value
Always	2707	69.05	6.72	-0.203	-0.023	0.237
Usually	2707	19.85	3.38	-0.203	0.061	0.001*
Never	2707	11.11	4.39	.803	-0.012	0.527

\*p <0.05

HAC score. However, this research was done prior to the COVID-19 pandemic. This study looked to examine if the pandemic changed the relationship between patient perception of cleanliness and HAC score performance. **Method:** A retrospective correlational study was performed to examine if the relationship between patient perception of cleanliness and the incidence of *Clostridioides difficile* (CDI) and Methicillin-Resistant *Staphylococcus aureus* (MRSA) HAIs, as defined by the facility's HAC score, were affected by the COVID-19 pandemic. Multiple Center for Medicare and Medicaid Services (CMS) datasets were utilized for the study. There were approximately 2700 acute care facilities that reported data on the HCAHPS perception of cleanliness question and either a MRSA or CDI HAC score for the period of January 1, 2021, to December 31st, 2021. Basic descriptive statistics and Spearman's rho correlation analyses were performed to examine the potential associations between the two scores. **Result:** For MRSA, the study found that as the percentage of patients who reported that their room was "always" clean increased, the hospital's HAC score decreased ( $r = -0.141, p < 0.001$ ). Additionally, as the percentage of patients who reported their room was "never" clean increased, the hospital's HAC score increased ( $r = 0.175, p = <0.001$ ). For *C. difficile*, the analysis also revealed that as the percentage of patients who reported their room was "always" clean increased, there was not a significant change in the hospital's HAC score ( $r = -0.023, p = 0.237$ ). There was also not a significant change in the HAC score when the percentage of patients who reported their room as "never" clean increased ( $r = -0.012, p = 0.527$ ).

**Conclusion:** The study found that for MRSA, a hospital's performance on the HCAHPS performance on patient perception of cleanliness is related to their performance on their HAC score. This did not hold true when looking at *C. difficile* infections, which is in contrast to the prior evidence. Further research is needed to determine if there are specific factors that may have influenced this change.

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**Reducing Blood Culture Contamination in Adult Patients with Cancer Presenting to the Emergency Department**

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**Background:** Infection is one of the most common complications of cancer and cancer treatment. Most patients admitted for fever or infection come

through the Emergency Department (ED), which is a primary site for blood culture collection. Contamination of blood cultures complicates the diagnoses, compromises quality of care, leads to unnecessary antibiotic exposure and increases financial burdens. It may also lead to unnecessary removal of central venous access devices or delay of critical therapy or procedures. At our institution, the contamination rate of blood cultures drawn in the ED was over twice that of the remainder of the hospital (2.8 versus 0.8), prompting this quality improvement project. Unlike on hospital floors, nurses, instead of phlebotomists, draw most blood cultures due to the urgency of managing suspected sepsis. Our aim was to decrease the ED contamination rate by 20 percent after the first PDSA cycle, and ultimately bring it on par with the remainder of the hospital. **Methods:** First, we compared ED contamination rates versus other hospital inpatient floors and outpatient centers over a three-month period. We then evaluated the contamination rates of ED nurses versus ED phlebotomists and peripheral versus central line blood draws. Process mapping and fishbone analysis helped identify practices contributing to higher contamination rates. Key drivers of these practices were diagrammed, and potential interventions were ranked on a prioritization matrix. **Results:** We identified use of alcohol rather than chlorhexidine swabs for peripheral disinfection and inconsistent techniques of blood draw by nurses as critical contributors to increased contamination rates in the ED. Our intervention was creating premade blood culture kits promoting the use of chlorhexidine swabs through availability and easy access in the fast-paced ED environment. Ten cubic centimeter (cc) syringes in the kits encouraged withdrawal of adequate blood samples in compliance with the 7-10 cc guideline. Designated nursing team leaders checked off ED nurses at the bedside, implementing education and adherence in using the blood culture collection kits. The average number of blood cultures in the emergency department was 1,400. A reduction in blood culture contamination from 2.46 percent to 1.89 percent was seen after two months. **Conclusions:** A guideline-driven, standardized blood culture collection process followed by ED nurses is vital to reducing blood culture contamination. Chlorhexidine is necessary to maintain the lowest contamination rates. Readily available premade blood culture kits improve compliance with materials and techniques associated with best practices.

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**Case-Control Study Design to Identify Attributable Risk Factors for Rare Yet Trending Healthcare-Associated Infections**

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**Introduction:** There are a number of tools available to healthcare epidemiologists for identification and investigation of healthcare-associated infections. For example, root cause analysis (RCA) is an evidence-based strategy for identifying process failures that resulted in infection. However, RCA is most valuable on a case-by-case basis. It is not an efficient tool for investigating numerous events that trend over time. Healthcare epidemiologists must use different strategies that are both efficient and powerful. A case-control study is a valuable option to investigate rare but recurrent infection events. The objective of this study was to demonstrate the utility of a case-control study design to detect attributable risk factors of cesarean section surgical site infections (SSI). **Methods:** We conducted a case-control study at a Level III childbirth center with data timeframe of January 1, 2021 to May 31, 2023. The project was approved by the institutions' Quality Improvement Review Board prior to implementation. Cases were identified using the National Healthcare Safety Network (NHSN) SSI event criteria and included all levels of SSI. Controls were selected from the NHSN surgical denominator and were matched randomly without replacement by age at a 1:4 ratio. Variables were identified in collaboration with stakeholders based on known risk factors for SSI and abstracted manually. Analyses