

the purview of any accrediting agencies, knowledge of and ability to adhere to standards or guidelines can be variable setting the stage for differential care.

We describe our experience to date with a centralized outpatient IP team in a large healthcare system, highlighting the most common IP gaps found on initial assessment and barriers to program implementation. Building support for these programs requires increasing awareness and socializing the benefits to health system administration. National benchmarking is needed for the necessary IP support in the outpatient setting, which incorporates the complexity of these sites and the number of clinics. An infection prevention program with access to trained infection preventionists has allowed for the (gradual) advancement of IP in ambulatory setting for our large, multi-state healthcare system. Our experience emphasizes the scale of this problem and why addressing it poses a challenge without coordinated effort and oversight.

Supplementary material. The supplementary material for this article can be found at <https://doi.org/10.1017/ice.2024.232>

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Response to “Healthcare worker attitudes on routine non-urological preoperative urine cultures: a qualitative assessment”

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Dear Editor,

I recently read the article titled “Healthcare Worker Attitudes on Routine Non-Urological Preoperative Urine Cultures: A Qualitative Assessment” by Friberg Walhof *et al.* (2024) with great interest.¹ The study provides valuable insights into the persistent use of preoperative urine cultures for asymptomatic bacteriuria (ASB), despite evidence-based guidelines recommending against their routine use in non-urological surgeries.^{2,3}

The authors effectively highlight the influence of perceived risks on clinical decision-making. However, I would like to contribute additional perspectives, particularly concerning the long-term implications of over-testing and overtreatment of ASB in surgical settings. The overprescription of antibiotics for ASB significantly contributes to the global challenge of antimicrobial resistance (AMR).⁴ Although the study touches on this issue, a stronger

emphasis on diagnostic stewardship is crucial.⁵ Clinicians, particularly in high-risk surgeries like orthopedics and cardiothoracic procedures, need targeted education to distinguish between true infection risks and unnecessary prophylactic treatments.⁶

The study also notes surgeons’ reluctance to discontinue urine cultures due to concerns about postoperative infections. In this context, multidisciplinary teams, including infection control specialists and antimicrobial stewardship pharmacists, could play a pivotal role in supporting the de-implementation process. These teams can provide peer-supported education, clarify current evidence, and emphasize the low risk of ASB-related complications in non-urological surgeries.²

Additionally, the psychological barriers to changing practice patterns, as outlined through the Dual Process Model, are well explored in the article. However, future interventions may benefit from incorporating behavioral science strategies to address cognitive biases that hinder guideline adherence.⁷ Personalized feedback and case-based discussions, focused on evidence-based outcomes, could offer an effective way to address these barriers within clinical practice.

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In conclusion, the qualitative insights offered by Friberg Walhof *et al.* make a significant contribution to understanding the persistence of routine preoperative urine cultures in non-urological surgeries. However, for effective de-implementation, a multidisciplinary approach enhanced education on the implications of AMR, and strategies for cognitive behavior modification are essential.

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Response to Mr. Babar's Letter to the Editor regarding "Healthcare worker attitudes on routine non-urological preoperative urine cultures: a qualitative assessment"

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We would like to reply to Mr. Babar's Letter to the Editor¹ in response to our recently published article, "Healthcare worker attitudes on routine non-urological preoperative urine cultures: a qualitative assessment."² We appreciate the interest in our paper and agree that this is an initial step toward improving urine culturing practices. The work described was actually the prelude to an intervention to de-implement routine testing that includes multidisciplinary teamwork, personalized case-based education, and directed feedback.

We have presented ongoing work that further explores attitudes toward interventions to reduce preoperative urine testing in non-urological surgeries.³ This research focuses on questions asked of clinician participants about the acceptability of 4 prospectively identified potential interventions to de-implement routine preoperative urine testing for asymptomatic bacteriuria: substitution of another infection prevention intervention, lab restrictions

on ordering urine tests, audit and feedback on guideline concordance, and interactive workshops on evidence.

We agree that cognitive behavior modification is a necessary, yet difficult step to reducing the number of unnecessary urine tests and subsequent antibiotics. All members of the multidisciplinary team want the patient to experience the best outcomes possible while utilizing evidence-based practices. Receipt of unnecessary antibiotics can lead to worse outcomes for individual patients. Our research team aims to develop and implement interventions that help all team members achieve this common goal, while also reducing unnecessary testing and treatment and ultimately decreasing the global burden of antimicrobial resistance.

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