BLOODSTREAM INFECTIONS (BSI)

EPIDEMIOLOGY, PATHOPHYSIOLOGY, AND PREVENTION

REBEKAH MOEHRING, MD, MPH

Duke University School of Medicine

dicon.medicine.duke.edu
dason.medicine.duke.edu

dicon DUKE INFECTION CONTROL OUTREACH NETWORK

dason DUKE ANTIMICROBIAL STEWARDSHIP OUTREACH NETWORK

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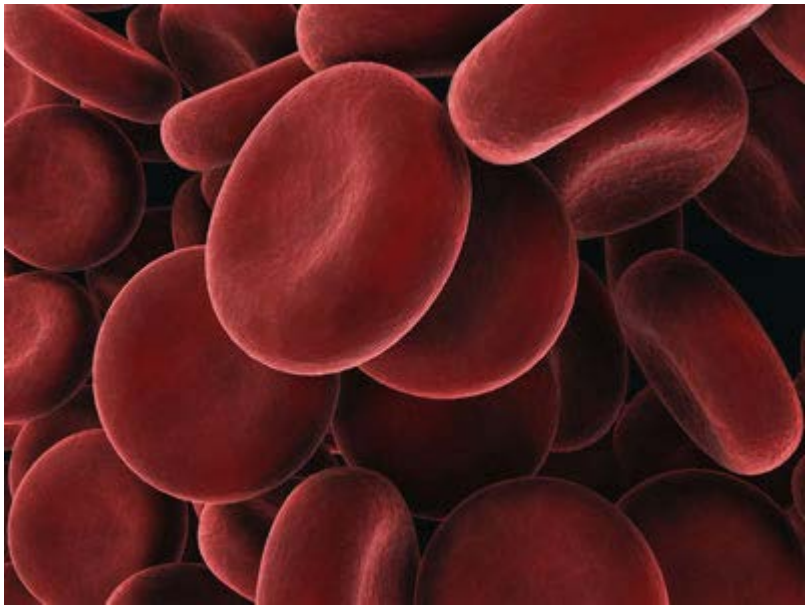


Objectives

Understand the impact of bloodstream infections

Understand the incidence and causative pathogens of bloodstream infection

Understand the risk factors for healthcare-associated bloodstream infections

Understand how we define bloodstream infection, both clinically and epidemiologically

Understand the prevention and control of bloodstream infections

BSI: Impact on Healthcare Population

Approximately 72,000 primary bloodstream infections per year

- Accounts for ~10% of healthcare-associated infections (rank = 5)

Rate of BSIs varies by:

- Hospital size, unit, and service
- Population served (elderly/infants, acute/chronic)
- Use and type of intravascular access device
- Time-trends
- Endemic/Epidemic

Major risk = central venous catheter

- CLABSI associated with increased length of stay and increased cost ($3,700 to $39,000 per episode)

Magill SS, et al. New Engl J Med 2014;370:1198; Marschall J, et al. ICHE 2014;35:753-771

Table 2. Distribution of 504 Health Care–Associated Infections.*

Type of Infection	Rank	No. of Infections	Percentage of All Health Care–Associated Infections (95% CI)
Pneumonia†	1 (tie)	110	21.8 (18.4–25.6)
Surgical-site infection	1 (tie)	110	21.8 (18.4–25.6)
Gastrointestinal infection	3	86	17.1 (14.0–20.5)
Urinary tract infection‡	4	65	12.9 (10.2–16.0)
Primary bloodstream infection§	5	50	9.9 (7.5–12.8)
Eye, ear, nose, throat, or mouth infection	6	28	5.6 (3.8–7.8)
Lower respiratory tract infection	7	20	4.0 (2.5–6.0)
Skin and soft-tissue infection	8	16	3.2 (1.9–5.0)
Cardiovascular system infection	9	6	1.2 (0.5–2.5)
Bone and joint infection	10	5	1.0 (0.4–2.2)
Central nervous system infection	11	4	0.8 (0.3–1.9)
Reproductive tract infection	12	3	0.6 (0.2–1.6)
Systemic infection	13	1	0.2 (0.01–1.0)

50 Primary BSI
42 (82%) CLABSI
37 Secondary BSI

Magill SS, et al. New Engl J Med 2014;370:1198

Central Lines: Utilization

Characteristic	All Patients (N = 11,282)	Patients without Health Care–Associated Infections (N = 10,830)	Patients with Health Care–Associated Infections (N = 452)	P Value†
Central catheter in place on survey date — no. (%)				
Any	2,121 (18.8)	1,862 (17.2)	259 (57.3)	<0.001
Femoral	54 (0.5)	44 (0.4)	10 (2.2)	
Peripherally inserted	1,037 (9.2)	878 (8.1)	159 (35.2)	
Other known type	1,057 (9.4)	958 (8.8)	99 (21.9)	
Unknown type	32 (0.3)	29 (0.3)	3 (0.7)	
None	9,140 (81.0)	8,948 (82.6)	192 (42.5)	
Missing data	21 (0.2)	20 (0.2)	1 (0.2)	

Magill SS, et al. New Engl J Med 2014;370:1198

Central Line Utilization by Unit

High: ICUs (Medical and Surgical)

Low: Psych, L&D/Postpartum, Ortho

Central line utilization ratio[¶]					Percentile				
Type of acute care hospital location	No. of locations[†]	Central line days	Patient days	Pooled mean	10%	25%	50% (median)	75%	90%
Medical/surgical: major teaching	358 (356)	800,019	1,482,658	0.54	0.28	0.39	0.53	0.65	0.71
Medical/surgical: all other, ≤15 beds	1,647 (1,627)	1,260,781	3,453,458	0.37	0.11	0.19	0.34	0.50	0.62
Medical/surgical: all other, >15 beds	807	2,132,226	4,391,341	0.49	0.30	0.40	0.51	0.60	0.69
Neurologic	59 (58)	80,894	171,989	0.47	0.22	0.32	0.46	0.55	0.67
Neurosurgical	181	317,745	731,728	0.43	0.24	0.34	0.43	0.54	0.60
Pediatric cardiothoracic	43	146,328	202,899	0.72	0.49	0.59	0.75	0.86	0.91
Pediatric medical	31 (29)	23,719	63,391	0.37	0.10	0.14	0.25	0.34	0.47
Pediatric medical/surgical	315 (307)	389,069	866,418	0.45	0.14	0.22	0.35	0.50	0.62
Pediatric surgical	6	3,105	9,609	0.32					
Prenatal	8	710	9,153	0.08					
Respiratory	6	9,842	26,288	0.37					
Surgical: major teaching	197	470,884	819,943	0.57	0.38	0.46	0.57	0.67	0.75
Surgical: all other	190 (188)	345,261							
Surgical cardiothoracic	455 (454)	955,534	1,						
Trauma	147	329,688							
Step-down units									
Adult step-down (postcritical care)	700 (699)	818,478	3,						
Step-down NICU (level II)	47 (44)	4,886	83,342	0.06	0.01	0.02	0.04	0.07	0.11
Pediatric step-down (postcritical care)	17	17,416	57,086	0.31					
Mixed acuity units[‡]									
Adult mixed acuity	83 (82)	83,286	336,340	0.25	0.04	0.10	0.19	0.35	0.49
Mixed age mixed acuity	49	28,758	204,837	0.14	0.03	0.06	0.10	0.20	0.32
Pediatric mixed acuity	16	29,140	125,440	0.23					
Inpatient wards									

$$\textbf{Device utilization ratio} = \frac{\text{No. of device days}}{\text{No. of patient days}}$$

Dudeck et al. AJIC 2015; 43: 206-221

Central Line Associated BSI (CLABSI) Rate by Unit

High: Burn, ICUs (Medical and Surgical), Trauma, Vent Unit

Low: Ortho, GYN, Psych

Table 3
Pooled means and key percentiles of the distribution of laboratory-confirmed central line–associated BSI rates and central line utilization ratios, by type of location, acute care hospitals, DA Module, 2013

Central line–associated BSI rate*					Percentile				
Type of acute care hospital location	No. of locations†	No. of CLABSIs	Central line days	Pooled mean	10%	25%	50% (median)	75%	90%
Critical care									
Burn	71 (69)	219	74,949	2.9	0.0	0.0	2.2	4.4	7.3
Medical: major teaching	251 (250)	812	669,976	1.2	0.0	0.4	1.0	1.8	2.8
Medical: all other	452 (432)	660	611,514	1.1	0.0	0.0	0.5	1.4	2.5
Medical cardiac	387 (381)	565	557,944	1.0	0.0	0.0	0.8	1.6	2.6
Medical/surgical: major teaching	358 (354)	908	800,019	1.1	0.0	0.0	0.9	1.6	2.4
Medical/surgical: all other, ≤15 beds	1,647 (1,510)	1,032	1,260,781	0.8	0.0	0.0	0.0	1.0	2.4
Medical/surgical: all other, >15 beds	807 (804)	1,752	2,132,226	0.8	0.0	0.0	0.6	1.2	2.0
Neurologic	59 (58)	91	80,894	1.1	0.0	0.0	0.9	1.6	2.8
Neurosurgical	181 (178)	300	317,745	0.9	0.0	0.0	0.7	1.4	2.2
Pediatric cardiothoracic									
Pediatric n									
Pediatric n									
Pediatric s									
Prenatal									
Respiratory									
Surgical: n									
Surgical: all other	190 (186)	295	345,261	0.9	0.0	0.0	0.7	1.4	2.5
Surgical cardiothoracic	455 (454)	777	955,534	0.8	0.0	0.0	0.5	1.2	2.1
Trauma	147	470	329,688	1.4	0.0	0.5	1.2	2.1	3.4
Step-down units									

$$\textbf{Device-associated infection rate} = \frac{\text{No. of device} - \text{associated infections for an infection site}}{\text{No. of device days}} \times 1{,}000$$

Dudeck et al. AJIC 2015; 43: 206-221

Definitions: IMPORTANT!

CLINICAL DEFINITION ≠ SURVEILLANCE DEFINITION

CLINICAL DEFINITION

What is BSI?

Bloodstream infection or Bacteremia:

Positive blood culture(s) +/- systemic signs of infection

Other terms:

- Septicemia: positive blood cultures + systemic signs of infection
- Sepsis and Septic Shock
- Pseudobacteremia or “contaminated” blood cultures: positive blood cultures resulting from contamination during the collection procedure or during laboratory processing

CLINICAL DEFINITION

What is BSI?

Primary BSI: NO identifiable originating source on clinical exam and/or diagnostics

Secondary BSI: Identifiable, localized infection at a specific site on clinical exam and/or diagnostics

Ex: Group B Streptococcus BSI

GBS BSI Source in Non-pregnant adults	%
Unknown (Primary)	30-40%
Skin and Soft Tissue	15-40%
Urinary Tract	5-15%
Upper Respiratory Tract	6-12%
Bone and Joint	2-15%
Cardiac/Endocarditis	2-9%
Central Nervous System	<4%

Source: UpToDate.

How do pathogens enter the bloodstream?

Many potential points/mechanisms of entry.

Disruption of skin or mucosal barriers:

- Localized infection advances to become systemic (Secondary BSI)
- Skin disruption, scratches, bug bites
- IV drug abuse
- Invasive devices (central venous catheter)
- Invasive procedures (surgical, dental, scopes)

Transient bacteremias may happen all the time but are usually cleared by the liver/spleen

Host considerations

- Implants/prostheses
- Impaired immunity

CLINICAL DEFINITION

Signs and symptoms

Systemic: Fever, chills, rigors, fatigue → hypotension, shock

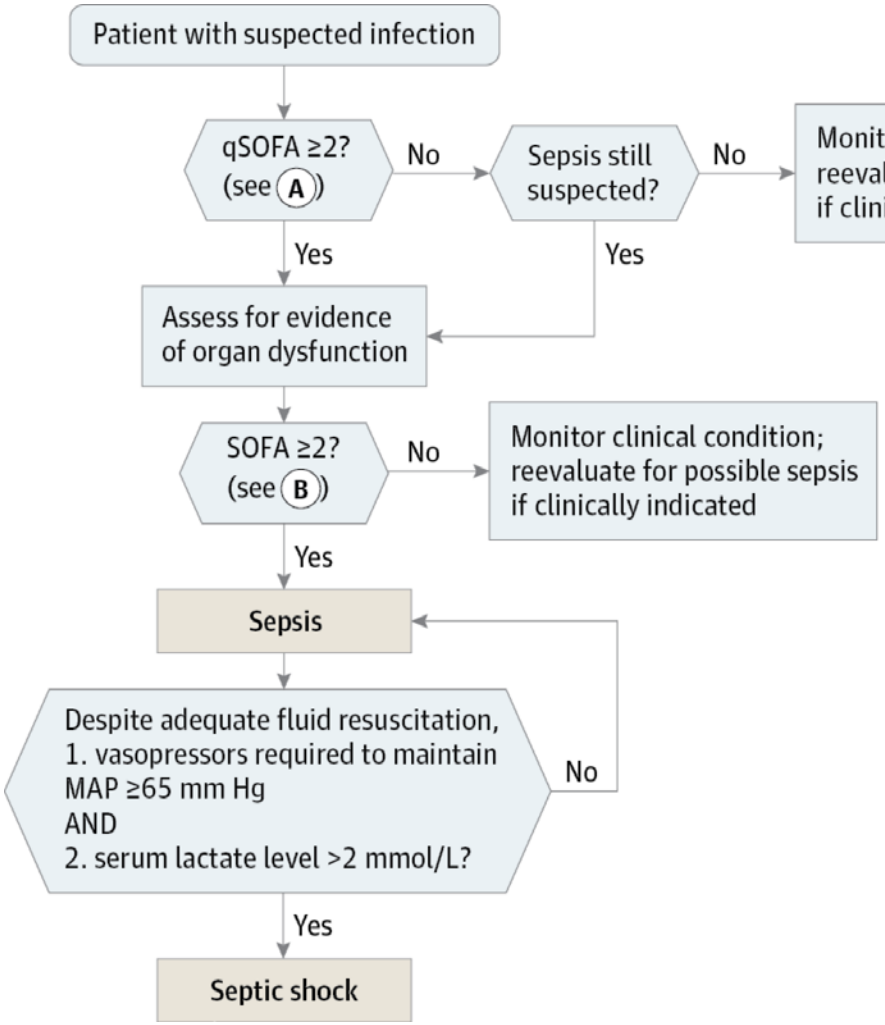
Respiratory: hyperventilation → respiratory failure

Neurologic: Confusion → seizure, coma

Secondary: Other localized infection symptoms

Localized infection **Fever** **Septic Shock + Organ Failure**

Recognize and Treat Sepsis



A qSOFA Variables

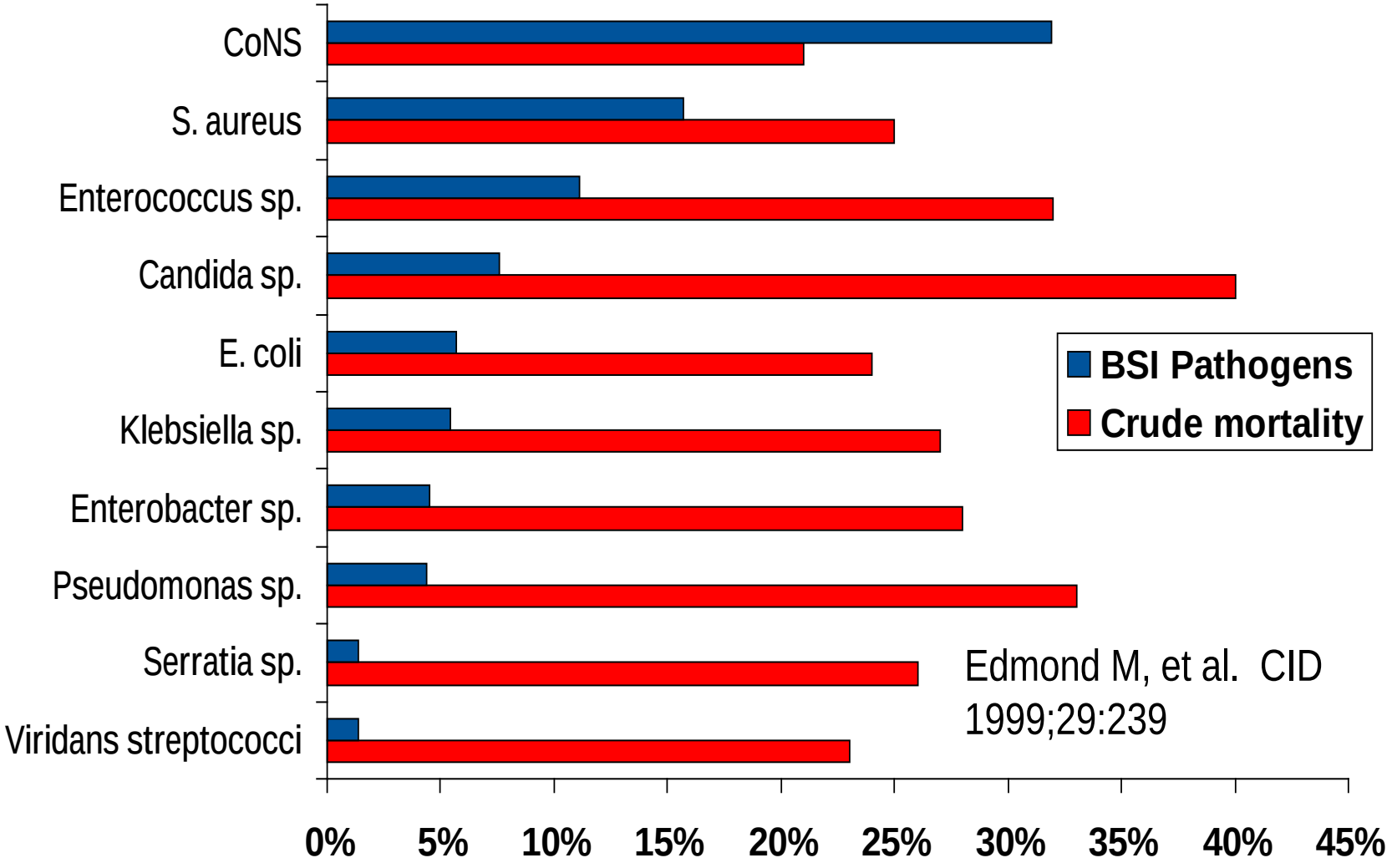
- Respiratory rate
- Mental status
- Systolic blood pressure

B SOFA Variables

- PaO_2/FiO_2 ratio
- Glasgow Coma Scale score
- Mean arterial pressure
- Administration of vasopressors with type and dose rate of infusion
- Serum creatinine or urine output
- Bilirubin
- Platelet count

JAMA. 2016;315(8):801-810

MORTALITY OF NOSOCOMIAL BSI, SCOPE, 1995-98



Clinical management: Go to the Source

1. Source control

- Incision and Drainage for abscesses
- Remove necrotic material
- Remove foreign material
- Contain bowel/bladder contents
- Wash out joints

2. Antibiotics and/or antifungals

- Initially IV
- *May* be able to transition to oral depending on: clinical progress, culture clearance, primary source, and organism/susceptibilities

3. Supportive Care

- Fluids, oxygen, ICU (pressors, vent)

CLINICAL DEFINITION

Central Venous Catheter Infections

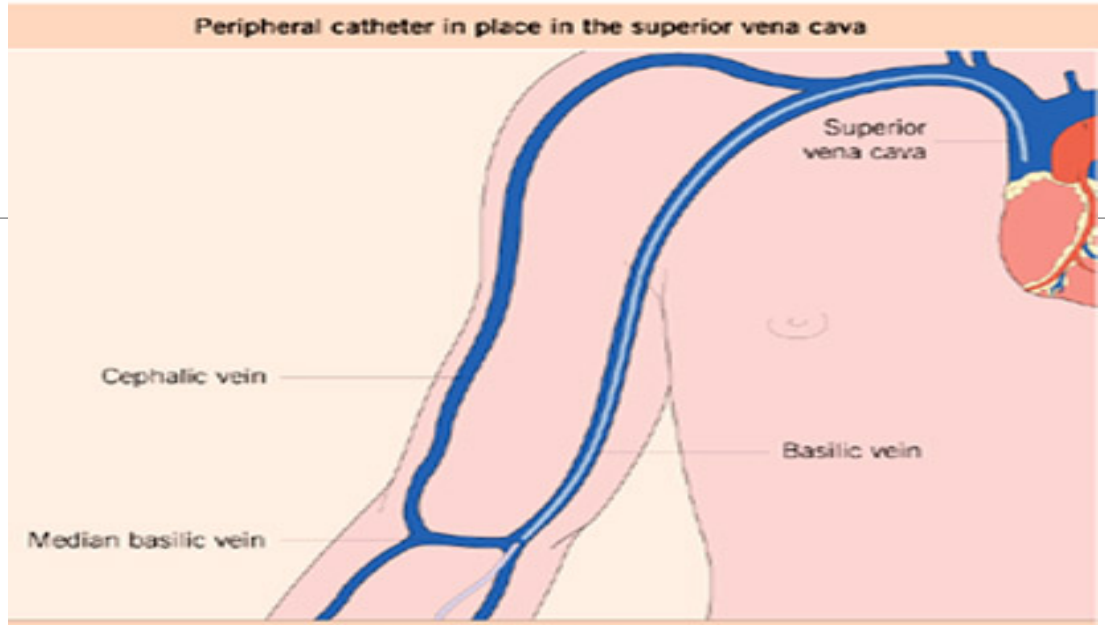
Infection	Definition
Catheter colonization	Significant growth of ≥1 microorganism in a quantitative or semiquantitative culture of the catheter tip, subcutaneous catheter segment, or catheter hub
Phlebitis	Induration or erythema, warmth, and pain or tenderness along the tract of a catheterized or recently catheterized vein
Exit site infection	
Microbiological	Exudate at catheter exit site yields a microorganism with or without concomitant bloodstream infection
Clinical	Erythema, induration, and/or tenderness within 2 cm of the catheter exit site; may be associated with other signs and symptoms of infection, such as fever or purulent drainage emerging from the exit site, with or without concomitant bloodstream infection[a]
Tunnel infection	Tenderness, erythema, and/or induration >2 cm from the catheter exit site, along the subcutaneous tract of a tunneled catheter (e.g., Hickman or Broviac catheter), with or without concomitant bloodstream infection[a]
Pocket infection	Infected fluid in the subcutaneous pocket of a totally implanted intravascular device; often associated with tenderness, erythema, and/or induration over the pocket; spontaneous rupture and drainage, or necrosis of the overlying skin, with or without concomitant bloodstream infection[a]
Bloodstream infection	
Infusate related	Concordant growth of a microorganism from infusate and cultures of percutaneously obtained blood cultures with no other identifiable source of infection
Catheter related	Bacteremia or fungemia in a patient who has an intravascular device and >1 positive blood culture result obtained from the peripheral vein, clinical manifestations of infection (e.g., fever, chills, and/or hypotension), and no apparent source for bloodstream infection (with the exception of the catheter). One of the following should be present: a positive result of semiquantitative (>15 cfu per catheter segment) or quantitative (>10^2 cfu per catheter segment) catheter culture, whereby the same organism (species) is isolated from a catheter segment and a peripheral blood culture; simultaneous quantitative cultures of blood with a ratio of >3:1 cfu/mL of blood (catheter vs. peripheral blood); differential time to positivity (growth in a culture of blood obtained through a catheter hub is detected by an automated blood culture system at least 2 h earlier than a culture of simultaneously drawn peripheral blood of equal volume). Note that this definition differs from the definition of central line–associated bloodstream infection used for infection-control surveillance activities.

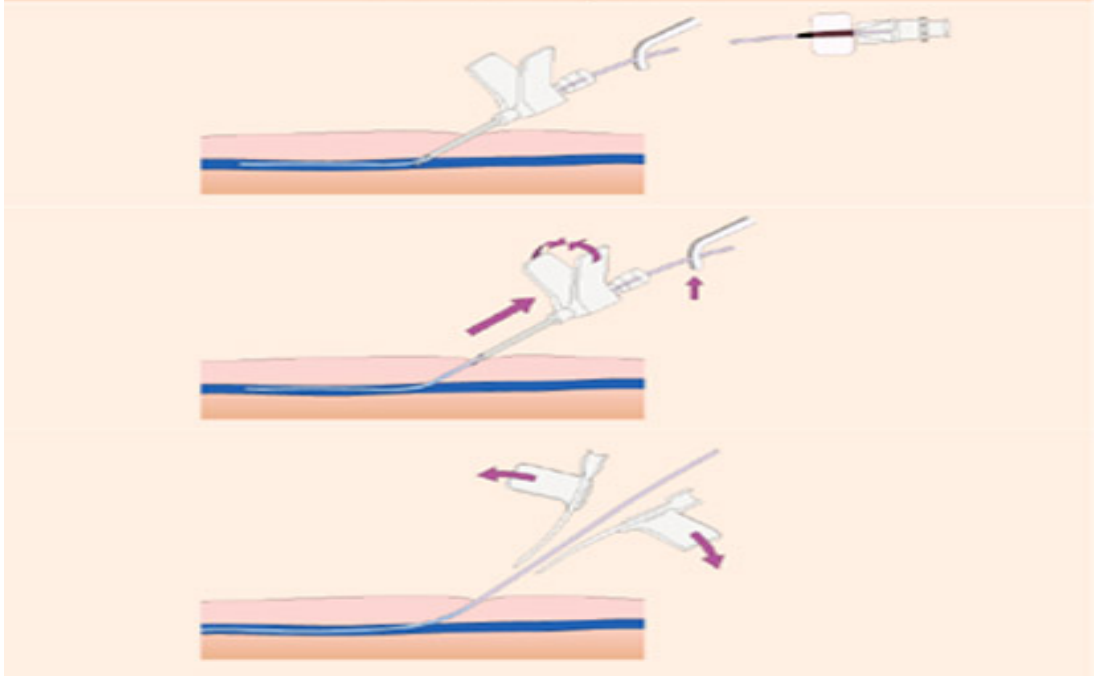
Mermel L, et al. CID 2009;49:1-45

Table 3. Types of intravascular devices and comments on their use.

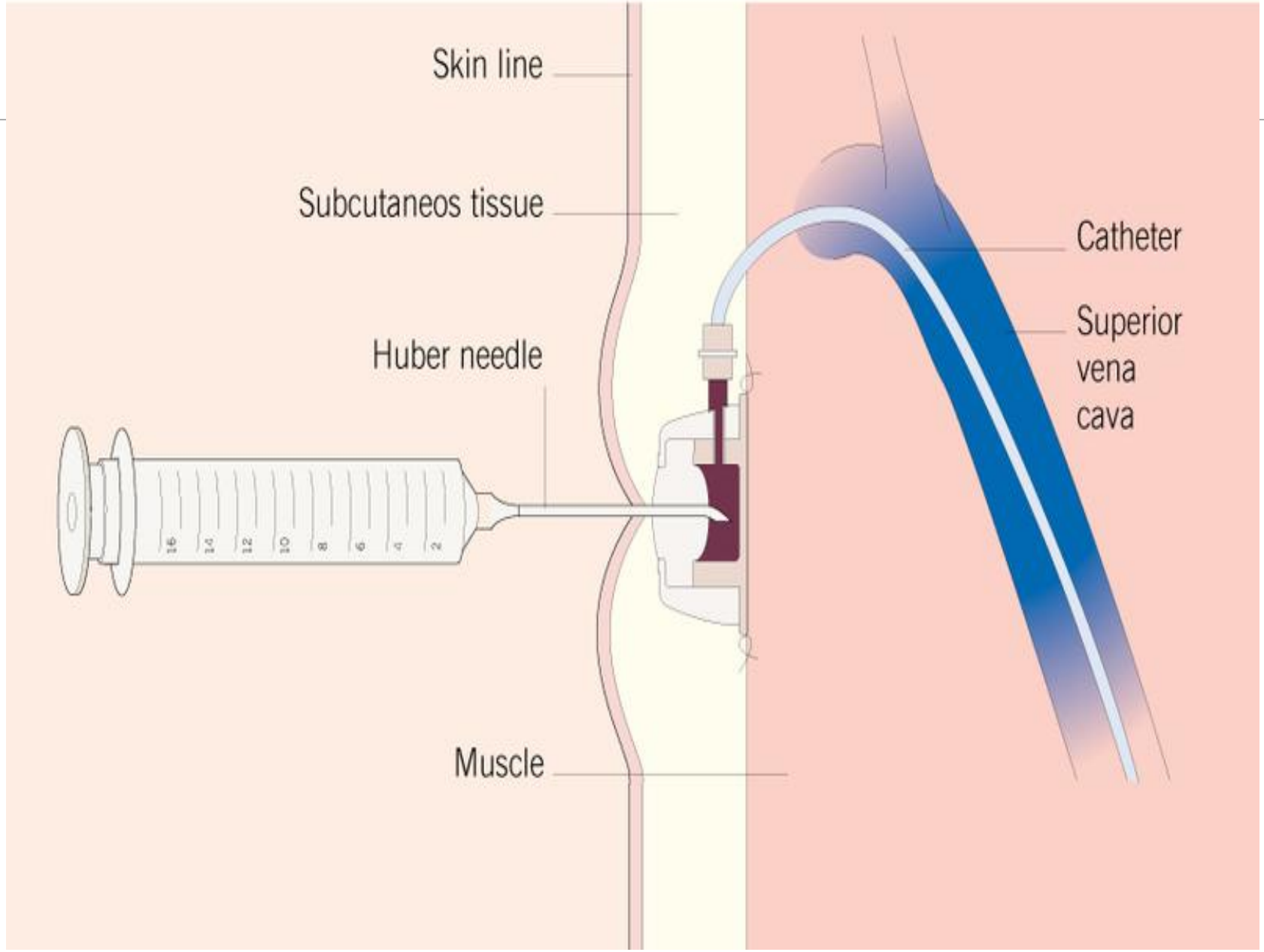
Type of intravascular device	Comment
Peripheral venous catheter	Usually inserted into the veins of the forearm or the hand; the most commonly used short-term intravascular device
Peripheral arterial catheter	For short-term use; commonly used to monitor hemodynamic status and to determine blood gas levels of critically ill patients; risk of bloodstream infection may approach that of CVCs
Midline catheter	Peripheral catheter (size, 7.6–20.3 cm) is inserted via the antecubital fossa into the proximal basilic or cephalic veins, but it does not enter central veins; it is associated with lower rates of infection, compared with CVCs
Short-term CVC	Most commonly used CVC; accounts for the majority of all catheter-related bloodstream infections
Pulmonary artery catheter	Inserted through a teflon introducer and typically remains in place for an average duration of only 3 days
Pressure-monitoring system	Used in conjunction with arterial catheter; associated with both epidemic and endemic nosocomial bloodstream infections
Peripherally inserted central catheter	Provides an alternative to subclavian or jugular vein catheterization; is inserted via the peripheral vein into the superior vena cava, usually by way of cephalic and basilar veins; similar risk of infection as CVCs in patients hospitalized in intensive care units
Long-term CVC	Surgically implanted CVC (e.g., Hickman, Broviac, or Groshong catheter) with the tunneled portion exiting the skin and a dacron cuff just inside the exit site; used to provide vascular access to patients who require prolonged chemotherapy, home-infusion therapy, or hemodialysis
Totally implantable device	A subcutaneous port or reservoir with self-sealing septum is tunneled beneath the skin and is accessed by a needle through intact skin; associated with low rates of infection

PERIPHERAL INSERTION OF CENTRAL VENOUS CATHETERS





SUBCUTANEOUS PORT FOR A CATHETER



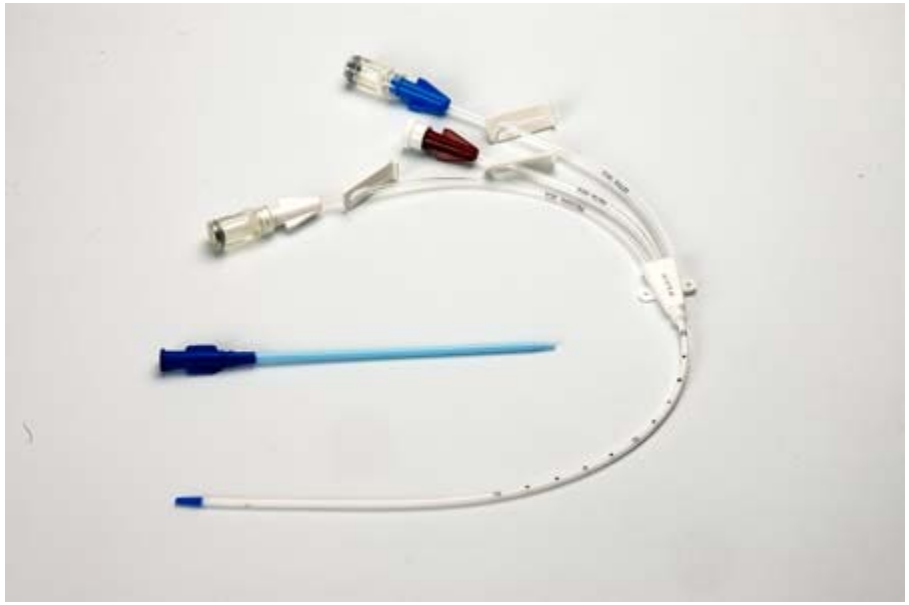
PATHOGENESIS Central Line Infection

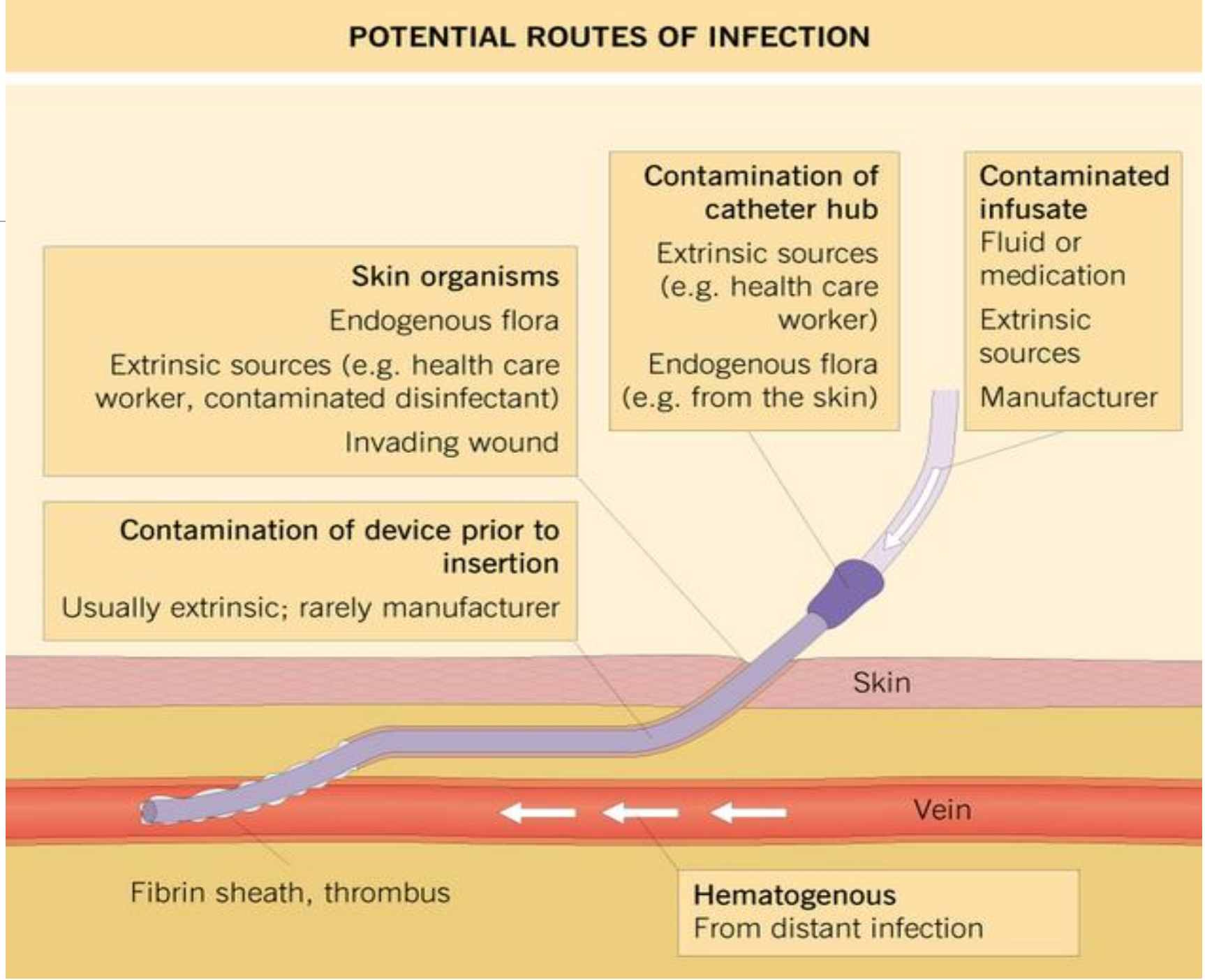
Multifactorial and complex

Most catheter-related infections appear to result form migration of skin organisms at insertion site into the cutaneous tract with eventual colonization of the catheter tip

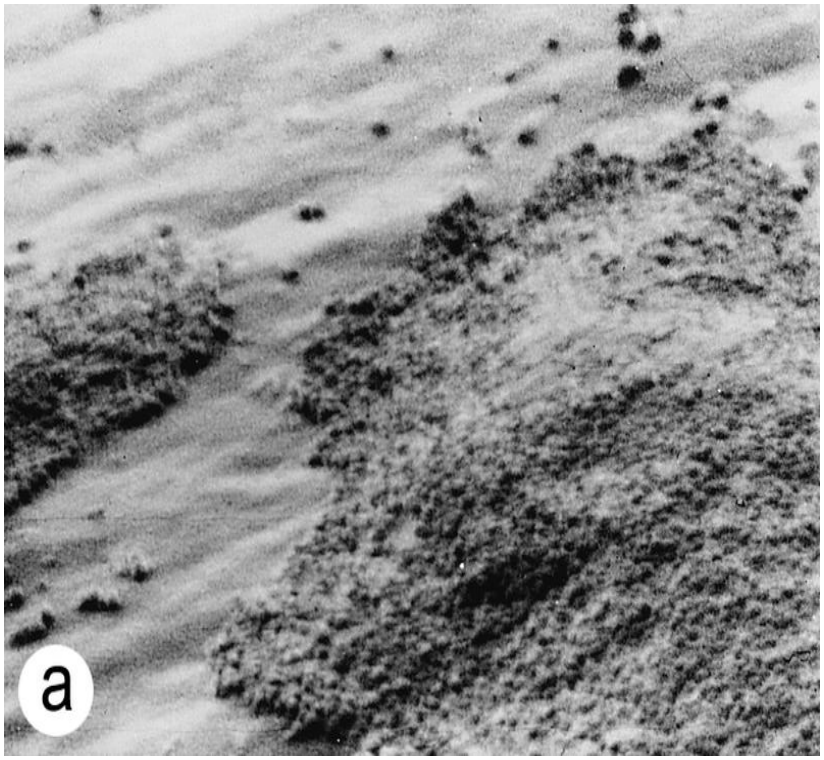
Catheter hub also important contributor to intralumenal colonization (especially in long-term catheters)

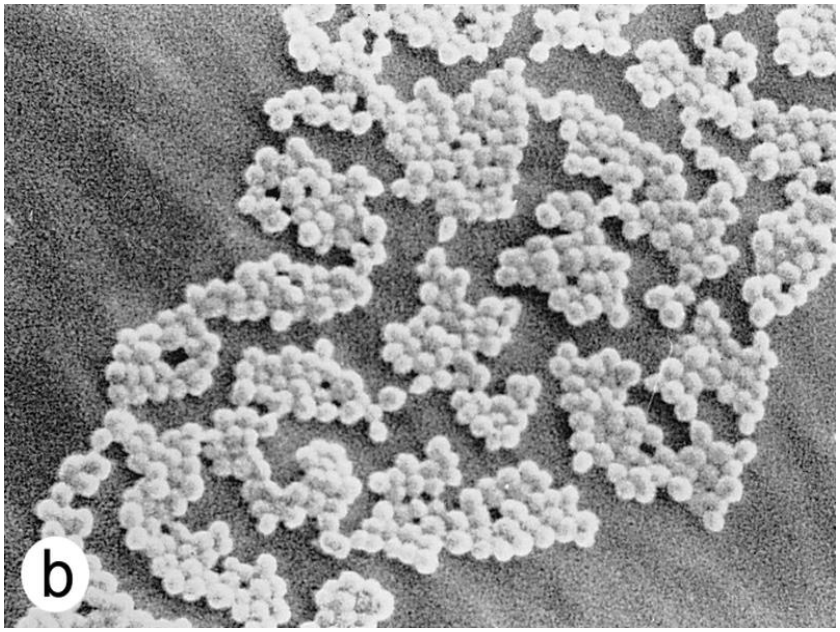
Less common = hematogenous seeding of catheter tip from distant focus of infection or contaminated infusate



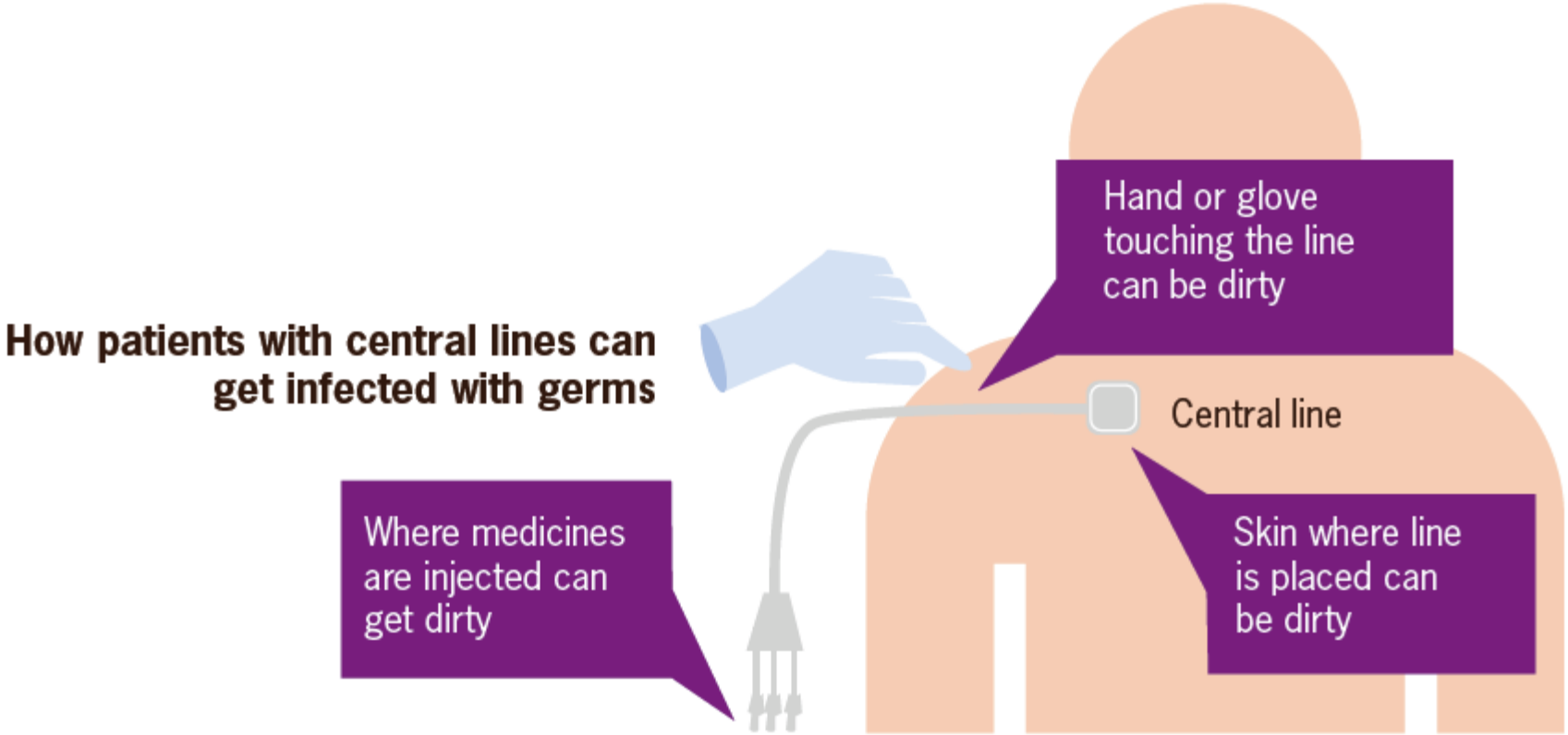

POTENTIAL ROUTES OF INFECTION
Contamination of catheter hub
Extrinsic sources (e.g. health care worker)
Endogenous flora (e.g. from the skin)
Contaminated infusate
Fluid or medication
Extrinsic sources
Manufacturer
Skin organisms
Endogenous flora
Extrinsic sources (e.g. health care worker, contaminated disinfectant)
Invading wound
Contamination of device prior to insertion
Usually extrinsic; rarely manufacturer
Skin
Vein
Fibrin sheath, thrombus
Hematogenous
From distant infection

BIOFILM



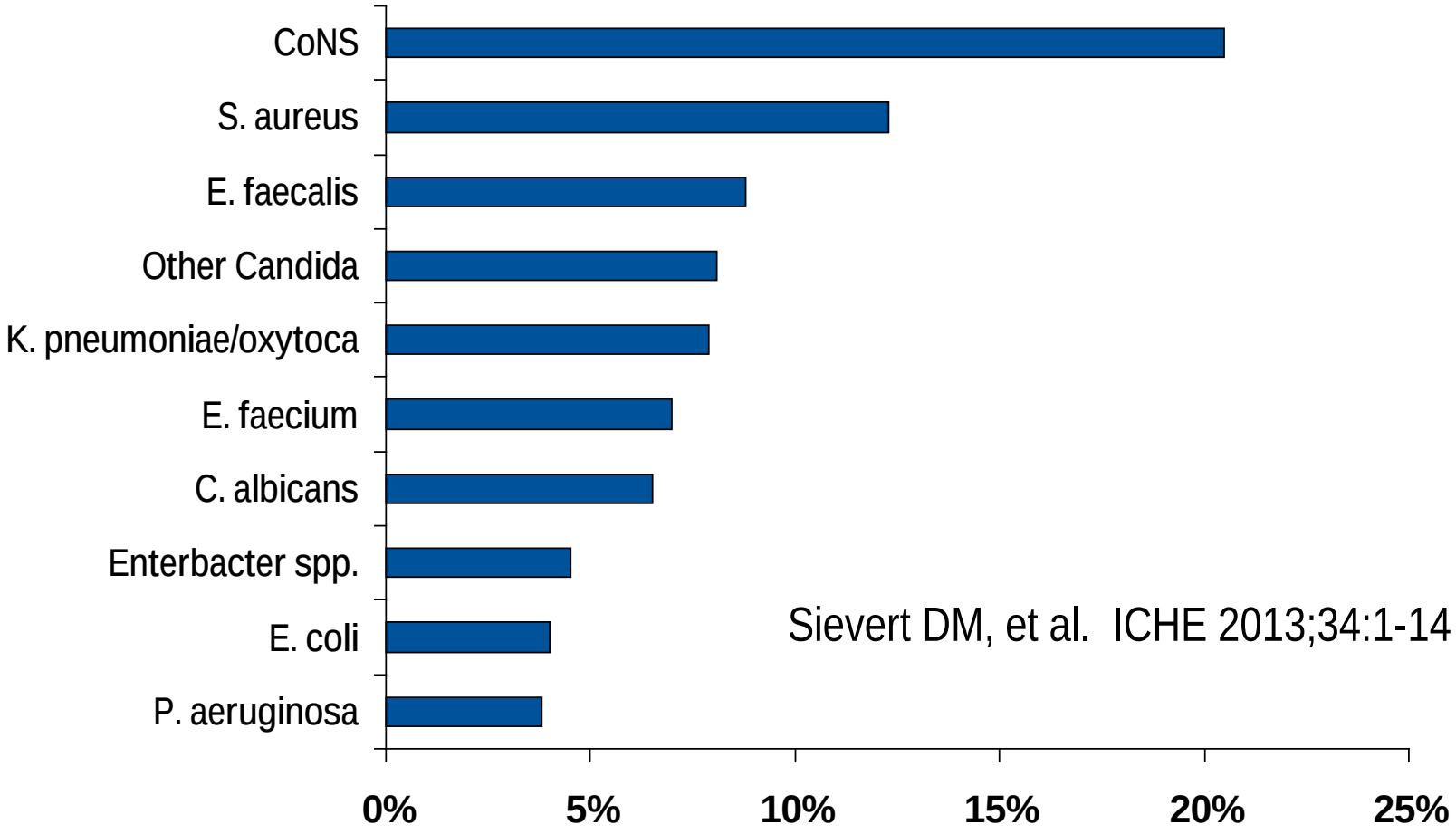


How does CLABSI happen?



CDC VitalSigns March 2011;60(8):243–248.

TOP 10 PATHOGENS ASSOCIATED WITH CLABSIs: NHSN, 2009-2010



COMPLICATIONS OF CLABSIs

Local infection
- Tunnel infection, pocket infection

Sepsis

Remote site infection
- Osteomyelitis
- Meningitis

Endovascular infection
- Endocarditis
- Mycotic aneurysms
- Septic thrombophlebitis

Populations at Higher Risk for CLABSI

ICU patients

- High CL utilization (often multiple CL at once and specialized lines)
- Catheters placed in emergencies circumstances
- Need for repeated access daily
- Often need CL for extended time periods

Vulnerable populations

- Hemodialysis
- Peri-operative
- Hem/Onc

Risk Factors for CLABSI*

INCREASED RISK FACTORS:

- Prolonged hospitalization prior to catheterization
- Prolonged duration of catheterization
- Heavy microbial colonization at the insertion site
- Heavy microbial colonization of the catheter hub
- Site of catheter (adults): Femoral (worst), Internal jugular, compared to Subclavian (best)
- Host Immunity: Neutropenia, neonate prematurity
- Reduced Nurse:Patient Ratios (ICU)
- TPN
- Substandard catheter care (e.g. excessive manipulation)
- Blood products (children)

DECREASED RISK/PROTECTIVE FACTORS:

- Female sex
- Antibiotic administration
- Minocycline-rifampin impregnated catheters

*In at least 2 observational studies
ICHE 2014; 35: 753-771.

CLINICAL CLUES of CVC INFECTIONS

CVC: Exit site infection (erythema, tenderness, purulence) or tunnel infection (erythema, tenderness, purulence, induration)

High grade bacteremia/fungemia (multiple positive cultures)

Abrupt onset, associated with shock

Symptoms/signs of sepsis (i.e., fever/ hypotension) without obvious source (no identifiable local infection)

Evidence of septic thrombophlebitis of great vein

Continued bacteremia/fungemia despite appropriate therapy

Symptoms/signs of sepsis plus catheter malfunction

Bacteremia with CoNS, *Candida, Bacillus, Corynebacterium*

Goals of Infection Surveillance: Improve Understanding

Estimate disease incidence:

- Assess program impact, detect outbreaks or problem areas to focus prevention efforts, understand and describe disease burden

Reliability, reproducibility

- Trend over time
- Valid and standardized to the degree possible among practice areas (internal validity)
- Compare to benchmarks (external validity)

The definitions are designed to reflect clinical “truth,” but there is NO method of measurement that is perfect.

Abiding by NHSN definitions improves validity AND provides protection when faced with external review or challenges to the data.

Definitions must be adjusted with time due to the dynamic nature of medicine.

SURVEILLANCE DEFINITION

What is BSI?

There are multiple surveillance definitions to be familiar with:

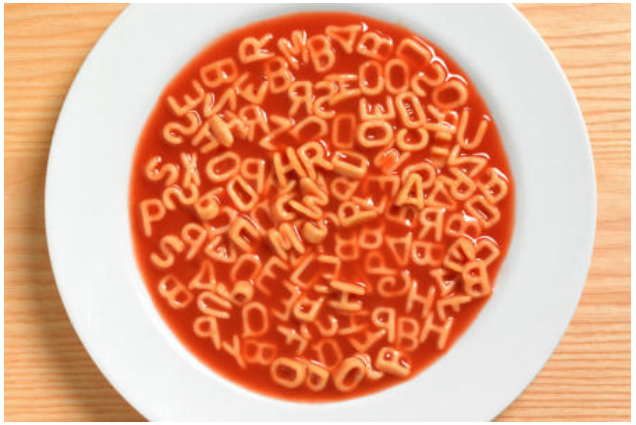
HAI

LCBSI

Secondary BSI due to other site-specific infection

MBI LCBSI

CLABSI



SURVEILLANCE DEFINITION

Healthcare Associated Infection (HAI)

All NHSN site specific infections must first meet the NHSN definition of HAI before a site specific infection (e.g., CLABSI) can be reported to NHSN

An infection is considered an HAI if:

- ALL elements of a CDC/NHSN site-specific infection criterion were *NOT present on admission* but were *ALL present on or after the 3rd calendar day* of admission to the facility.

All elements of the site-specific definition must occur within a time frame that:

- *Does not exceed* a gap of 1 calendar day between any two adjacent elements

SURVEILLANCE DEFINITION

Laboratory Confirmed BSI (LCBSI)

Must meet ONE of 3 criteria

3 LCBI criteria:

- Recognized pathogen (1 +cx)
- Common skin commensal (≥2 separate +cx with ≤1 day gap between)
- Neonates + common skin commensal

For all: organism cultured from blood is *not related to infection at another site*

Most closely reflects a clinical Primary BSI.

SURVEILLANCE DEFINITION

LCBSI Criterion 1

Patient has a recognized pathogen identified from *one or more blood specimens* by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).

AND

organism cultured from blood is *not related to an infection at another site*

Recognized Pathogen (Examples)
S. aureus
P. aeruginosa
E. coli
K. pneumoniae
S. marcescens
C. Albicans
Enterococcus sp.

SURVEILLANCE DEFINITION

LCBSI Criterion 2

Patient has at least one of the following signs or symptoms: fever (>38.0oC), chills or hypotension

AND

Organism(s) identified from blood is *not related to an infection at another site*

AND

The same common commensal (see list) is identified from *2 or more* blood cultures drawn on separate occasions, by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing ASC/AST).

Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the date the positive blood culture was collected, the 3 calendar days before and the 3 calendar days after

Common Commensals (Partial List)

Diphtheroids [Corynebacterium spp. not C. diphtheriae]
Bacillus spp. [not B. anthracis]
Propionibacterium spp.
Coagulase-negative staphylococci [including S. epidermidis]
Viridans group streptococci
Aerococcus spp.
Micrococcus spp.

SURVEILLANCE DEFINITION

LCBSI Criterion 3

Patient ≤ 1 year of age has at least one of the following signs or symptoms: fever (>38.0C), hypothermia (<36.0C), apnea, or bradycardia

AND

Organism(s) identified from blood is *not related to an infection at another site*

AND

The same common commensal is identified from *two or more blood* specimens drawn on separate occasions (see comment 5 below), by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).

Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after.

Common Commensals (Partial List)

Diphtheroids [Corynebacterium spp. not C. diphtheriae]
Bacillus spp. [not B. anthracis]
Propionibacterium spp.
Coagulase-negative staphylococci [including S. epidermidis]
Viridans group streptococci
Aerococcus spp.
Micrococcus spp.

Secondary
To Another Infection?

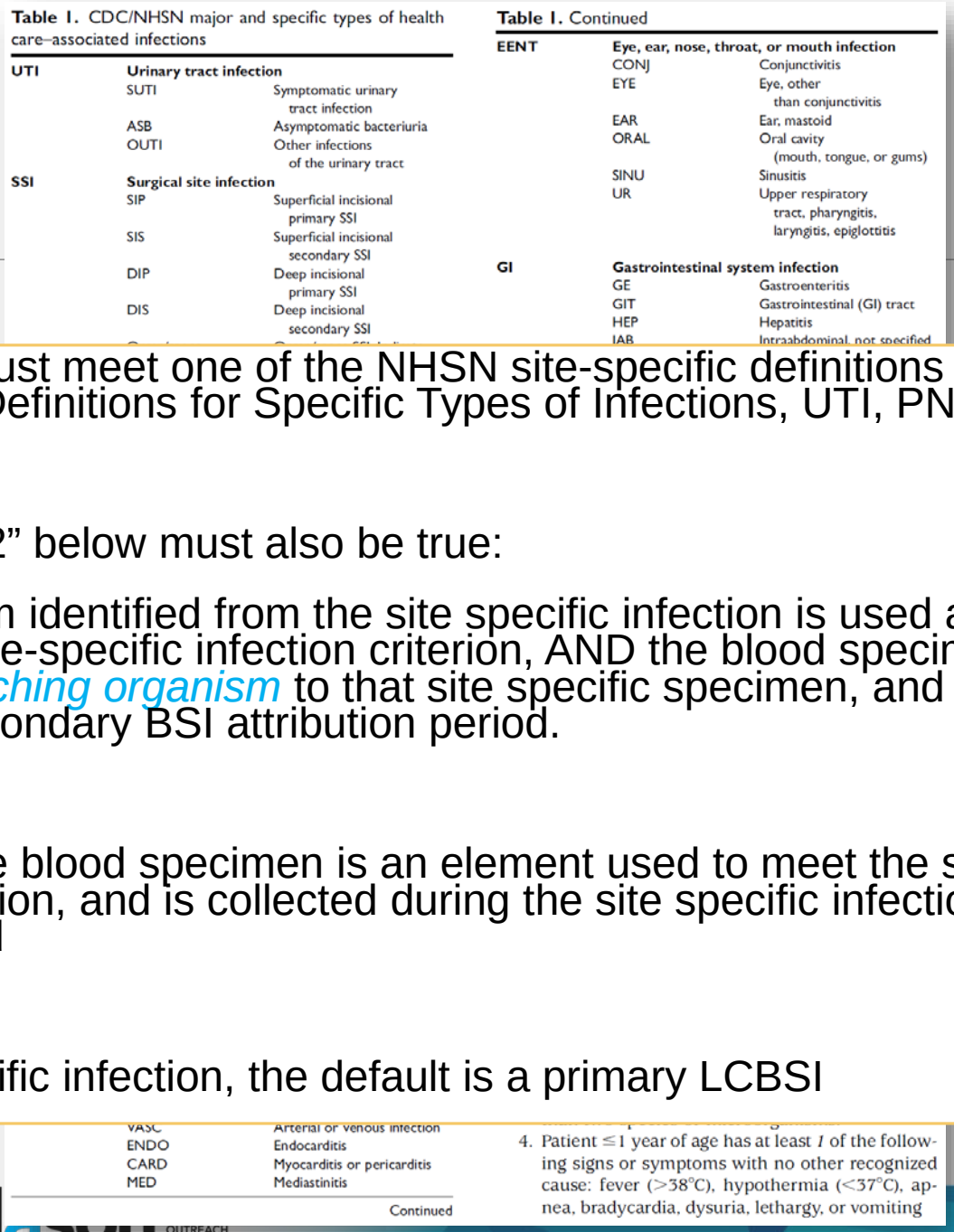


Table 1. CDC/NHSN major and specific types of health care–associated infections

UTI	**Urinary tract infection**	
	SUTI	Symptomatic urinary tract infection
	ASB	Asymptomatic bacteriuria
	OUTI	Other infections of the urinary tract
SSI	**Surgical site infection**	
	SIP	Superficial incisional primary SSI
	SIS	Superficial incisional secondary SSI
	DIP	Deep incisional primary SSI
	DIS	Deep incisional secondary SSI
	VASC	Arterial or venous infection
	ENDO	Endocarditis
	CARD	Myocarditis or pericarditis
	MED	Mediastinitis

Continued

Table 1. Continued

EENT	**Eye, ear, nose, throat, or mouth infection**	
	CONJ	Conjunctivitis
	EYE	Eye, other than conjunctivitis
	EAR	Ear, mastoid
	ORAL	Oral cavity (mouth, tongue, or gums)
	SINU	Sinusitis
	UR	Upper respiratory tract, pharyngitis, laryngitis, epiglottitis
GI	**Gastrointestinal system infection**	
	GE	Gastroenteritis
	GIT	Gastrointestinal (GI) tract
	HEP	Hepatitis
	IAB	Intraabdominal, not specified

4. Patient ≤1 year of age has at least *1* of the following signs or symptoms with no other recognized cause: fever (>38°C), hypothermia (<37°C), apnea, bradycardia, dysuria, lethargy, or vomiting

The patient must meet one of the NHSN site-specific definitions (CDC/NHSN Surveillance Definitions for Specific Types of Infections, UTI, PNEU or SSI),

AND

Either “1” or “2” below must also be true:

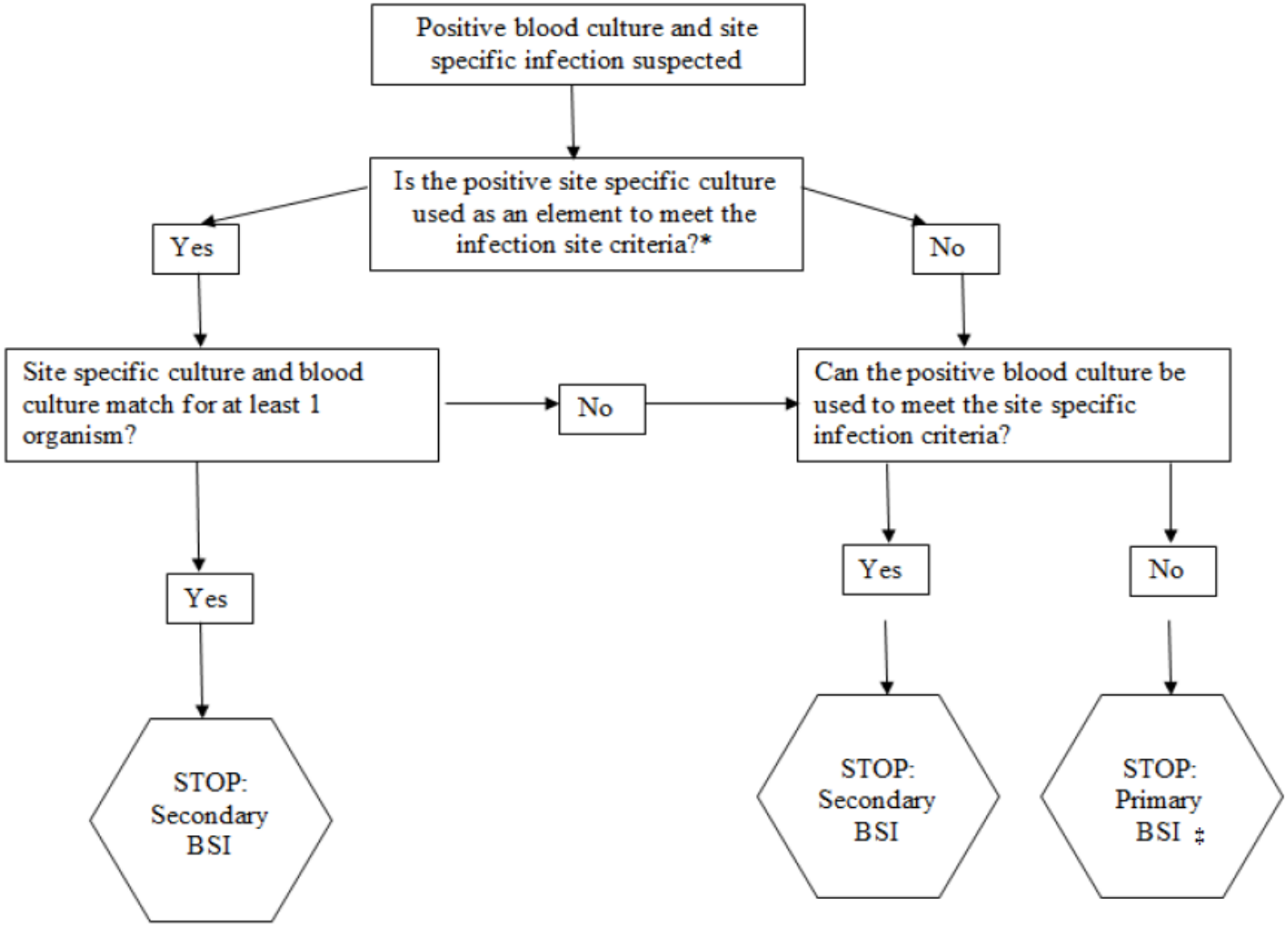
1. An organism identified from the site specific infection is used as an element to meet the site-specific infection criterion, AND the blood specimen contains *at least one matching organism* to that site specific specimen, and is collected during the secondary BSI attribution period.

OR

2. The positive blood specimen is an element used to meet the site-specific infection criterion, and is collected during the site specific infection’s infection window period

If no site-specific infection, the default is a primary LCBSI

SECONDARY BSI GUIDE FOR ELIGIBLE ORGANISMS (not applicable to VAE)



Hem/Onc/BMT a "special population":

Complex patient population	• Highly toxic treatments • ICU stays • Complications (infection, bleeding, ADEs)
Device utilization	• True need for central line
Culturing practices	• Bad veins • Thrombocytopenia
Antimicrobial utilization	• Like water • Usually appropriate for severity of illness
Surveillance practices	• Variable?
Administrative pressure	• "Protective" of program and reputation
Adjudication	• Clinicians don't consider many "CLABSI" to be preventable • Definitions don't apply well to patient population and leads to rejection of data

SURVEILLANCE DEFINITION

MBI-BSI Criterion 1

Patient of any age meets criterion 1 for LCBI with at least one blood specimen identified by a culture or non-culture based microbiologic testing method, with any of the following *intestinal organisms* (but no other organisms).

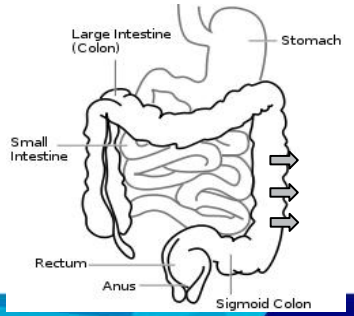
AND patient meets at least one of the following:

1. Is an allogeneic hematopoietic stem cell transplant recipient within the past year with one of the following documented during same hospitalization as positive blood specimen:
   - Grade III or IV gastrointestinal graft versus host disease [GI GVHD]
   - ≥1 liter diarrhea in a 24-hour period (or ≥20 mL/kg in a 24-hour period for patients <18 years of age) with onset on or within 7 calendar days before the date the positive blood specimen was collected.

2. Is neutropenic, defined as at least two separate days with values of absolute neutrophil count (ANC) or total white blood cell count (WBC) <500 cells/mm3 within a 7-day time period which includes the date the positive blood specimen was collected (Day 1), the 3 calendar days before and the 3 calendar days after.

Intestinal pathogens (partial list)

Bacteroides spp.
Candida spp.
Clostridium spp.
Enterococcus spp.
Fusobacterium spp.
Peptostreptococcus spp.
Prevotella spp.
Veillonella spp.
Enterobacteriaceae



SURVEILLANCE DEFINITION

MBI-BSI Criterion 2

Patient of any age meets criterion 2 for LCBI with at least one blood specimen identified by a culture or non-culture based microbiologic testing method, with only viridans group streptococci and no other organisms.

AND patient meets at least one of the following:

1. Is an allogeneic hematopoietic stem cell transplant recipient within the past year with one of the following documented during same hospitalization as positive blood specimen:
   - Grade III or IV gastrointestinal graft versus host disease [GI GVHD]
   - ≥1 liter diarrhea in a 24-hour period (or ≥20 mL/kg in a 24-hour period for patients <18 years of age) with onset on or within 7 calendar days before the date the positive blood specimen was collected.

2. Is neutropenic, defined as at least two separate days with values of absolute neutrophil count (ANC) or total white blood cell count (WBC) <500 cells/mm3 within a 7-day time period which includes the date the positive blood specimen was collected (Day 1), the 3 calendar days before and the 3 calendar days after.

SURVEILLANCE DEFINITION

MBI-BSI Criterion 3

Patient ≤1 year of age meets criterion 3 for LCBI with at least one blood specimen identified by a culture or non-culture based microbiologic testing method, with only viridans group streptococci and no other organisms.

AND patient meets at least one of the following:

1. Is an allogeneic hematopoietic stem cell transplant recipient within the past year with one of the following documented during same hospitalization as positive blood specimen:
   - Grade III or IV gastrointestinal graft versus host disease [GI GVHD]
   - ≥20 mL/kg diarrhea in a 24-hour period with onset on or within 7 calendar days before the date the first positive blood specimen is collected.

2. Is neutropenic, defined as at least two separate days with values of absolute neutrophil count (ANC) or total white blood cell count (WBC) <500 cells/mm3 on or within a seven-day time period which includes the date the positive blood specimen was collected (Day 1), the 3 calendar days before and the 3 calendar days after.

SURVEILLANCE DEFINITION

Central Line

Central line

- Catheter must terminate in aorta, pulmonary artery, superior or inferior vena cava, brachiocephalic veins, internal jugular veins, subclavian veins, external iliac or common iliac veins, femoral veins, umbilical artery/vein (neonates)

The following are NOT considered central lines:

- Extracorporeal membrane oxygenation (ECMO)
- Arterial catheters
- Intra-aortic balloon pump (IABP) devices
- Hemodialysis reliable outflow (HeRO) dialysis catheters
- Non-accessed central line (not accessed nor inserted during the hospitalization)
- Peripheral IV or Midlines
- Ventricular Assist Device (VAD)

Infusion: Introduction of a solution through a blood vessel via a catheter lumen

SURVEILLANCE DEFINITION

Central Line

Temporary central line: A non-tunneled, non-implanted catheter

Permanent central line:

- Tunneled catheters, including certain dialysis catheters
- Implanted catheters (including ports)

SURVEILLANCE DEFINITION

CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI) EVENT

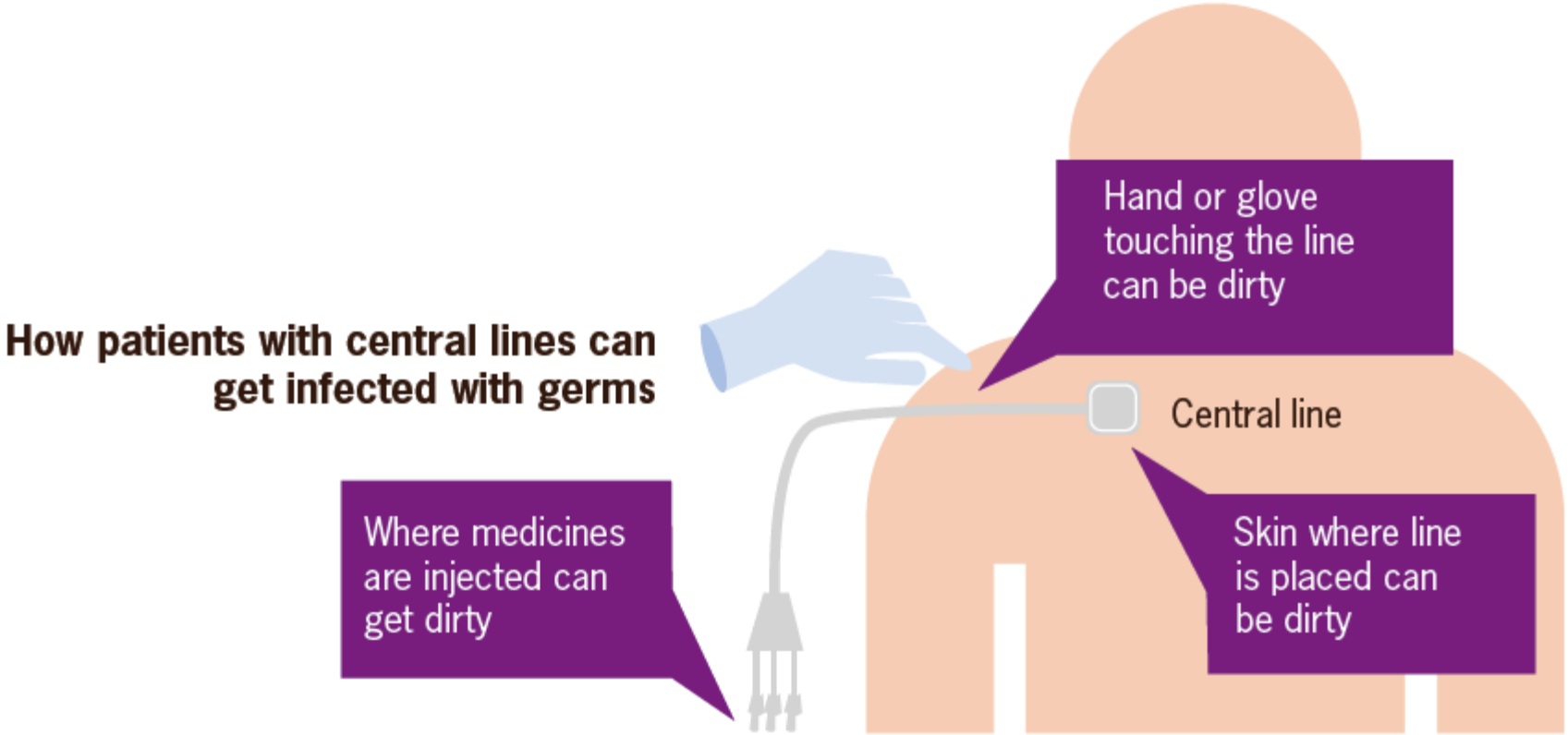
A laboratory-confirmed bloodstream infection (LCBI) where central line (CL) or umbilical catheter (UC) was in place for >2 calendar days when all elements of the LCBI were first present, with day of device placement being Day 1

AND

A CL or UC was in place on the day of the event or the day before. If a patient is admitted or transferred into a facility with a central line in place, day of first access is considered Day 1

http://www.cdc.gov/nhsn/acute-care-hospital/clabsi/index.html

How does CLABSI happen?



CDC VitalSigns March 2011;60(8):243–248.

Contamination occurs…

Insertion:

- Patient's Skin
- Operator (Spit, Hair, Hands)
- Environment

Maintenance:

- Cap is frequently accessed, inadequately cleaned during access, or poorly functioning
- Operator (Spit, Hair, Hands) during assessments + routine dressing changes
- Bacterial migration along catheter tract from skin

CLABSI Prevention Success!

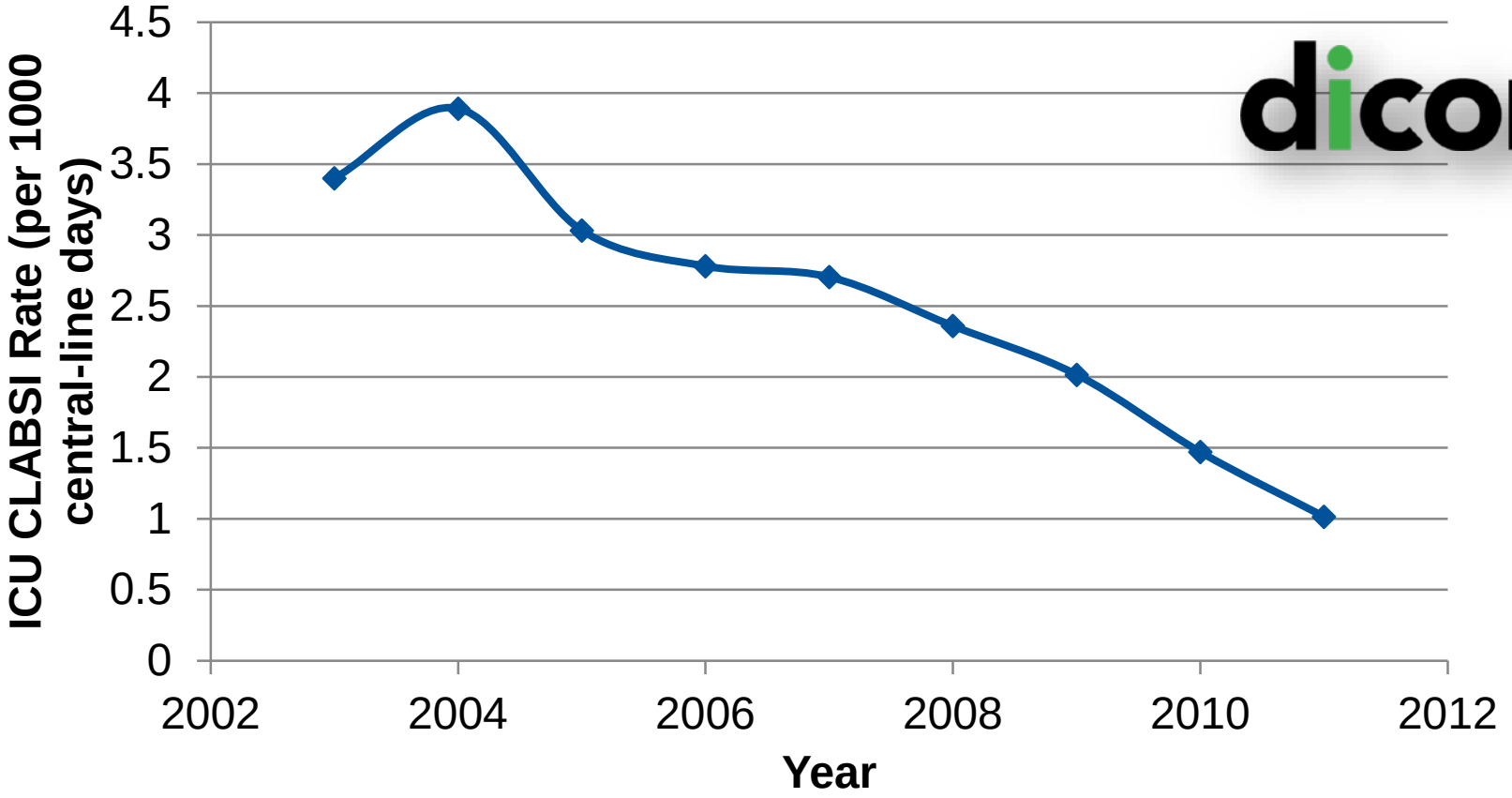
CLABSI incidence is downtrending

46% fewer CLABSI in hospital ICU patients in 2013 than in 2008

Prevention efforts have saved ~ 3,000-6,000 lives and ~$414 million in extra medical costs (2009 compared with 2001)

But, CLABSIs still occur: ~30,000 per year

MMWR 2011;60(8):243–248.



	DICON Average	10%	25%	50% (median)	75%	90%
2014 ICU CLABSI	0.8	0.0	0.0	0.0	0.8	1.4
2014 House-wide CLABSI	0.69	0.00	0.25	0.53	0.79	1.85

DICON: Unpublished data

NATIONAL

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.

Decrease 2008 to 2013

CLABSIs

46% LOWER COMPARED TO NAT'L BASELINE*

CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- U.S. hospitals reported a significant decrease in CLABSIs between 2012 and 2013.
- 9% Among the 2,389 hospitals in U.S. with enough data to calculate an SIR, 9% had an SIR significantly worse than the national SIR of 0.54.

CAUTIs

6% HIGHER COMPARED TO NAT'L BASELINE*

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- U.S. hospitals reported a significant increase in CAUTIs between 2012 and 2013.
- 12% Among the 2,781 U.S. hospitals with enough data to calculate an SIR, 12% had an SIR significantly worse than the national SIR of 1.06.

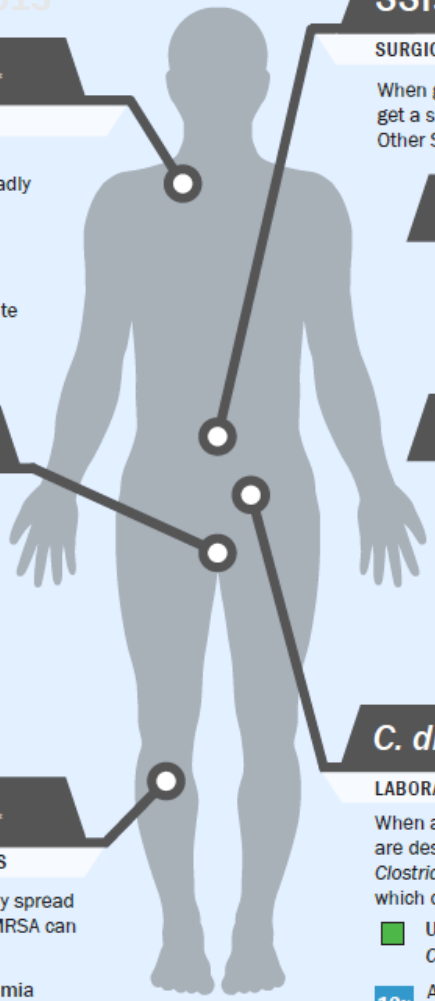
MRSA Bacteremia

8% LOWER COMPARED TO NAT'L BASELINE*

LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- U.S. hospitals reported a significant decrease in MRSA Bacteremia between 2012 and 2013.
- 7% Among the 2,002 U.S. hospitals with enough data to calculate an SIR, 7% had an SIR significantly worse than the national SIR of 0.92.



SSIs

SURGICAL SITE INFECTIONS *See page 3 for additional procedures*

When germs get into an area where surgery is or was performed, patients can get a surgical site infection. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

SSI: Abdominal Hysterectomy

14% LOWER COMPARED TO NAT'L BASELINE*

- U.S. hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- 6% Among the 765 U.S. hospitals with enough data to calculate an SIR, 6% had an SIR significantly worse than the national SIR of 0.86.

SSI: Colon Surgery

8% LOWER COMPARED TO NAT'L BASELINE*

- U.S. hospitals reported a significant increase in SSIs related to colon surgery between 2012 and 2013.
  - Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.
- 7% Among the 2,030 U.S. hospitals with enough data to calculate an SIR, 7% had an SIR significantly worse than the national SIR of 0.92.

C. difficile Infections

10% LOWER COMPARED TO NAT'L BASELINE*

LABORATORY IDENTIFIED HOSPITAL-ONSET *C. DIFFICILE* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- U.S. hospitals reported a significant decrease in *C.difficile* infections between 2012 and 2013.
- 13% Among the 3,557 U.S. hospitals with enough data to calculate an SIR, 13% had an SIR significantly worse than the national SIR of 0.90.

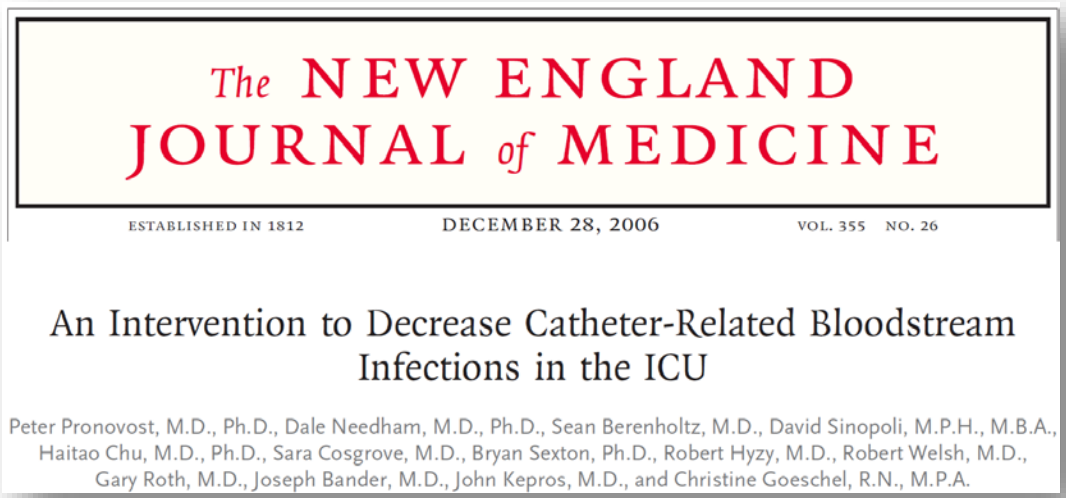
* Statistically significant.

THIS REPORT IS BASED ON 2013 DATA, PUBLISHED JANUARY 2015

What's a Bundle?

Institute for Healthcare Improvement

"Care bundles are small, straightforward, sets of evidence-based practices… that, when implemented collectively, improve the reliability of their delivery and improve patient outcomes."



The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 DECEMBER 28, 2006 VOL. 355 NO. 26

An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU

Peter Pronovost, M.D., Ph.D., Dale Needham, M.D., Ph.D., Sean Berenholtz, M.D., David Sinopoli, M.P.H., M.B.A., Haitao Chu, M.D., Ph.D., Sara Cosgrove, M.D., Bryan Sexton, Ph.D., Robert Hyzy, M.D., Robert Welsh, M.D., Gary Roth, M.D., Joseph Bander, M.D., John Kepros, M.D., and Christine Goeschel, R.N., M.P.A.

http://www.ihi.org/resources/Pages/ImprovementStories/WhatIsaBundle.aspx

IHI Bundle: PREVENTION OF CENTRAL LINE INFECTIONS

During insertion:

- Hand hygiene
- Maximal barrier precautions
- Chlorhexidine skin antisepsis (now CHG-alcohol)
- Optimal catheter site selection, with subclavian vein as the preferred site for nontunneled catheters

During maintenance:

- Daily review of line necessity, with prompt removal of unnecessary lines

Institute for Healthcare Improvement

SHEA/IDSA PRACTICE RECOMMENDATION

Strategies to Prevent Central Line–Associated Bloodstream Infections in Acute Care Hospitals: 2014 Update

Jonas Marschall, MD;[1,2,a] Leonard A. Mermel, DO, ScM;[3,a] Mohamad Fakih, MD, MPH;[4] Lynn Hadaway, MEd, RN, BC, CRNI;[5] Alexander Kallen, MD, MPH;[6] Naomi P. O'Grady, MD;[7] Ann Marie Pettis, RN, BSN, CIC;[8] Mark E. Rupp, MD;[9] Thomas Sandora, MD, MPH;[10] Lisa L. Maragakis, MD, MPH;[11] Deborah S. Yokoe, MD, MPH[12]

GRADING THE QUALITY OF EVIDENCE

Grade	Definition
I. High	Highly confident that the true effect lies close to that of the estimated size and direction of the effect. Evidence is rated as high quality when there is a wide range of studies with no major limitations, there is little variation between studies, and the summary estimate has a narrow confidence interval.
II. Moderate	The true effect is likely to be close to the estimated size and direction of the effect, but there is a possibility that it is substantially different. Evidence is rated as moderate quality when there are only a few studies and some have limitations but not major flaws, there is some variation between studies, or the confidence interval of the summary estimate is wide.
III. Low	The true effect may be substantially different from the estimated size and direction of the effect. Evidence is rated as low quality when supporting studies have major flaws, there is important variation between studies, the confidence interval of the summary estimate is very wide, or there are no rigorous studies, only expert consensus.

NOTE. Based on Grades of Recommendation, Assessment, Development, and Evaluation (GRADE)[239] and the Canadian Task Force on Preventive Health Care.[240]

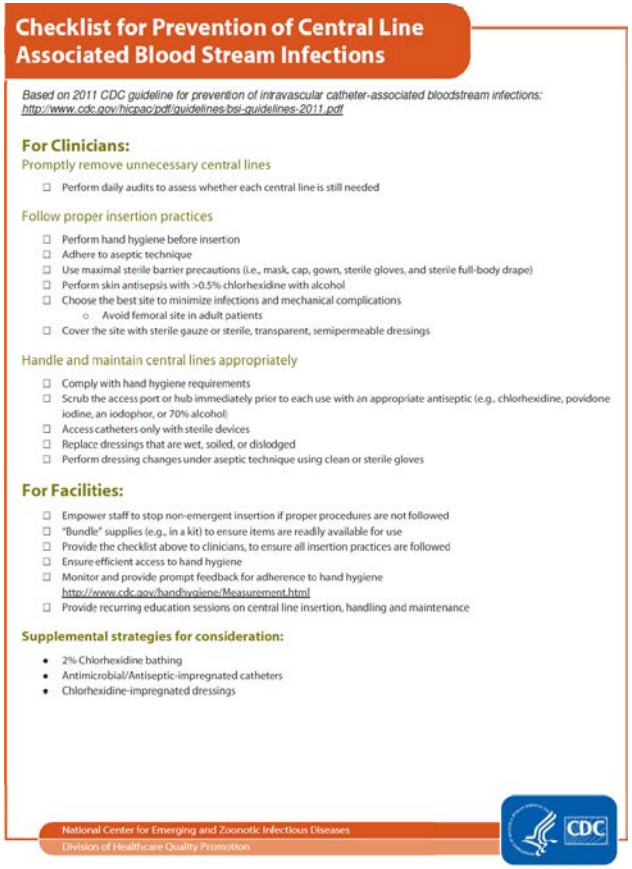
PREVENTING CLABSI: BEFORE INSERTION

Provide easy access to an evidence-based list of indications for CVC {III}

Require education of HCP involved in insertion, care, and maintenance of CVCs about CLABSI prevention {II}

Bathe ICU patients over 2 mo of age with a CHG preparation on a daily basis {I}

CDC EDUCATIONAL MATERIAL



Checklist for Prevention of Central Line Associated Blood Stream Infections

Based on 2011 CDC guideline for prevention of intravascular catheter-associated bloodstream infections:
http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf

For Clinicians:

Promptly remove unnecessary central lines

- ☐ Perform daily audits to assess whether each central line is still needed

Follow proper insertion practices

- ☐ Perform hand hygiene before insertion
- ☐ Adhere to aseptic technique
- ☐ Use maximal sterile barrier precautions (i.e., mask, cap, gown, sterile gloves, and sterile full-body drape)
- ☐ Perform skin antisepsis with >0.5% chlorhexidine with alcohol
- ☐ Choose the best site to minimize infections and mechanical complications
  - ○ Avoid femoral site in adult patients
- ☐ Cover the site with sterile gauze or sterile, transparent, semipermeable dressings

Handle and maintain central lines appropriately

- ☐ Comply with hand hygiene requirements
- ☐ Scrub the access port or hub immediately prior to each use with an appropriate antiseptic (e.g., chlorhexidine, povidone iodine, an iodophor, or 70% alcohol)
- ☐ Access catheters only with sterile devices
- ☐ Replace dressings that are wet, soiled, or dislodged
- ☐ Perform dressing changes under aseptic technique using clean or sterile gloves

For Facilities:

- ☐ Empower staff to stop non-emergent insertion if proper procedures are not followed
- ☐ "Bundle" supplies (e.g., in a kit) to ensure items are readily available for use
- ☐ Provide the checklist above to clinicians, to ensure all insertion practices are followed
- ☐ Ensure efficient access to hand hygiene
- ☐ Monitor and provide prompt feedback for adherence to hand hygiene
  http://www.cdc.gov/handhygiene/Measurement.html
- ☐ Provide recurring education sessions on central line insertion, handling and maintenance

Supplemental strategies for consideration:

- 2% Chlorhexidine bathing
- Antimicrobial/Antiseptic-impregnated catheters
- Chlorhexidine-impregnated dressings

National Center for Emerging and Zoonotic Infectious Diseases
Division of Healthcare Quality Promotion

FAQs
(frequently asked questions)

about
"Catheter-Associated Bloodstream Infections"
(also known as "Central Line-Associated Bloodstream Infections")

What is a catheter-associated bloodstream infection?

A "central line" or "central catheter" is a tube that is placed into a patient's large vein, usually in the neck, chest, arm, or groin. The catheter is often used to draw blood, or give fluids or medications. It may be left in place for several weeks. A bloodstream infection can occur when bacteria or other germs travel down a "central line" and enter the blood. If you develop a catheter-associated bloodstream infection you may become ill with fevers and chills or the skin around the catheter may become sore and red.

Can a catheter-related bloodstream infection be treated?

A catheter-associated bloodstream infection is serious, but often can be successfully treated with antibiotics. The catheter might need to be removed if you develop an infection.

What are some of the things that hospitals are doing to prevent catheter-associated bloodstream infections?

To prevent catheter-associated bloodstream infections doctors and nurses will:

- Choose a vein where the catheter can be safely inserted and where the risk for infection is small.
- Clean their hands with soap and water or an alcohol-based hand rub before putting in the catheter.
- Wear a mask, cap, sterile gown, and sterile gloves when putting in the catheter to keep it sterile. The patient will be covered with a sterile sheet.
- Clean the patient's skin with an antiseptic cleanser before putting in the catheter.
- Clean their hands, wear gloves, and clean the catheter opening with an antiseptic solution before using the catheter to draw blood or give medications. Healthcare providers also clean their hands and wear gloves when changing the bandage that covers the area where the catheter enters the skin.
- Decide every day if the patient still needs to have the catheter. The catheter will be removed as soon as it is no longer needed.
- Carefully handle medications and fluids that are given through the catheter.

What can I do to help prevent a catheter-associated bloodstream infection?

- Ask your doctors and nurses to explain why you need the catheter and how long you will have it.
- Ask your doctors and nurses if they will be using all of the prevention methods discussed above.
- Make sure that all doctors and nurses caring for you clean their hands with soap and water or an alcohol-based hand rub before and after caring for you.

If you do not see your providers clean their hands, please ask them to do so.

- If the bandage comes off or becomes wet or dirty, tell your nurse or doctor immediately.
- Inform your nurse or doctor if the area around your catheter is sore or red.
- Do not let family and friends who visit touch the catheter or the tubing.
- Make sure family and friends clean their hands with soap and water or an alcohol-based hand rub before and after visiting you.

What do I need to do when I go home from the hospital?

Some patients are sent home from the hospital with a catheter in order to continue their treatment. If you go home with a catheter, your doctors and nurses will explain everything you need to know about taking care of your catheter.

- Make sure you understand how to care for the catheter before leaving the hospital. For example, ask for instructions on showering or bathing with the catheter and how to change the catheter dressing.
- Make sure you know who to contact if you have questions or problems after you get home.
- Make sure you wash your hands with soap and water or an alcohol-based hand rub before handling your catheter.
- Watch for the signs and symptoms of catheter-associated bloodstream infection, such as soreness or redness at the catheter site or fever, and call your healthcare provider immediately if any occur.

If you have additional questions, please ask your doctor or nurse.

Co-sponsored by:

http://www.cdc.gov/HAI/bsi/bsi.html

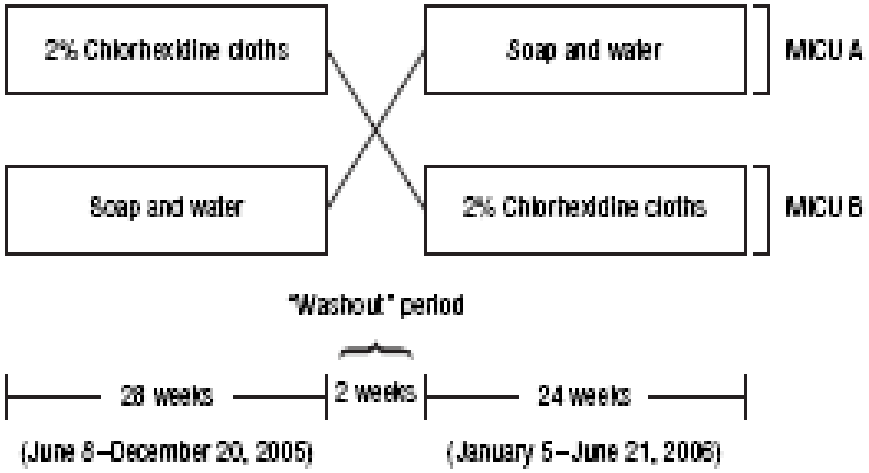
BATHE ICU PATIENTS >2 MONTHS OF AGE WITH A CHG PREPARATION DAILY

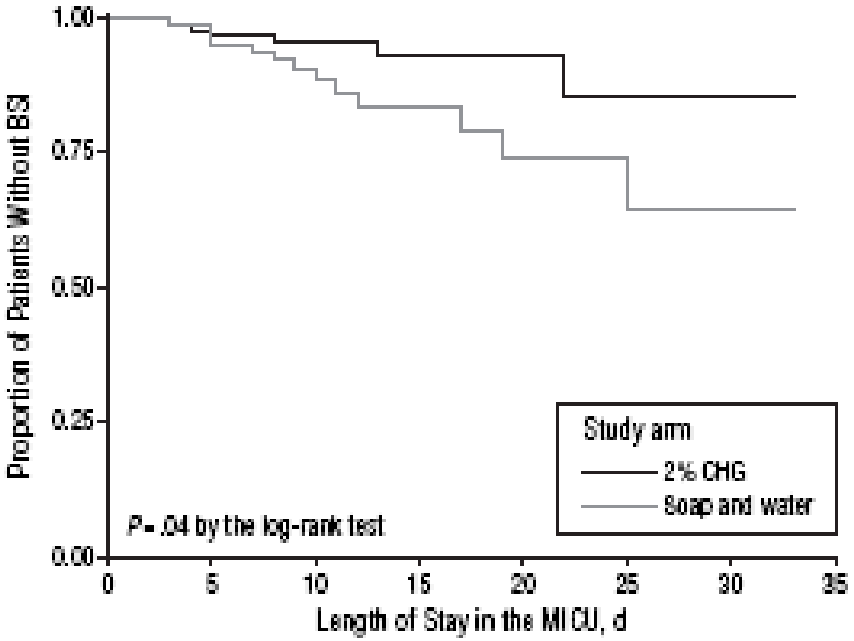
Intervention = Daily bathing with 2% CHG impregnated washcloth

Design & setting : Cross-over study in MICU

Result: CHG associated with decreased

rate (per 1,000 pt-days) of CLABSI (4.1 vs 10.4)

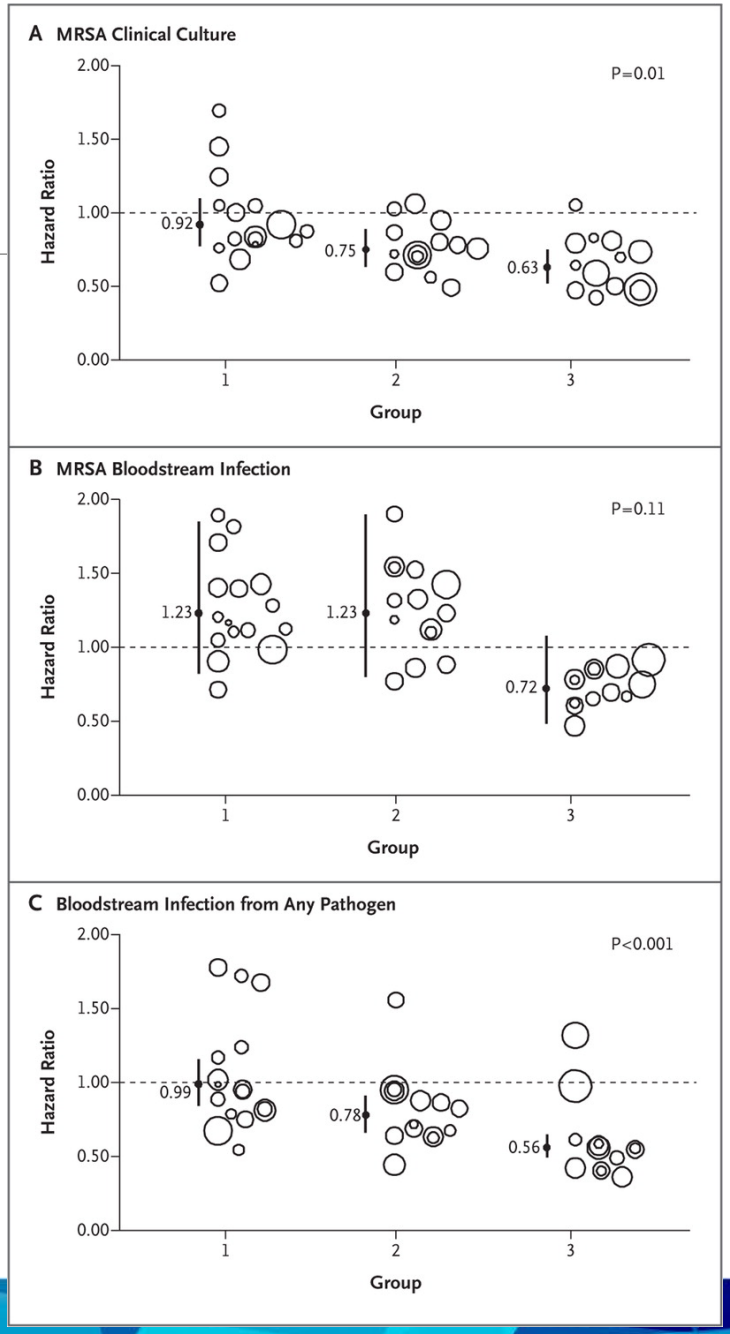




Bleasdale S, et al. Arch Intern Med 2007;167:2073

REDUCE MRSA

- Cluster-randomized trial in 74 ICUs
- MRSA screening and isolation vs. targeted decolonization of MRSA carriers vs. universal decolonization
- Decolonization: CHG daily bathing + nasal mupirocin
- Result: Universal decolonization reduced rate of all Primary BSI significantly. Decreased MRSA BSI also, but NS.
- 1 BSI prevented per 99 patients decolonized.



Huang SS et al. N Engl J Med 2013;368:2255-2265.

PREVENTING CLABSI: AT INSERTION

Have a process in place to ensure adherence to infection prevention practices (e.g., checklist){II}

Perform hand hygiene prior to catheter insertion or manipulation {II}

Avoid using the femoral artery for central venous access in obese patients {I}

- Consider risks and benefits of different insertion sites
- Do not used peripherally inserted CVCs (PICCs) as a strategy to reduce CLABSI

Use an all-inclusive catheter cart or kit {II}

Use ultrasound guidance for internal jugular insertion {II}

Use maximum sterile barrier precautions during CVC insertion (mask, cap, sterile gown, and sterile gloves; patient covered with full body sterile drape) {II}

Use alcohol-chlorhexidine for skin antisepsis {I}

CVC Bundle Checklist:

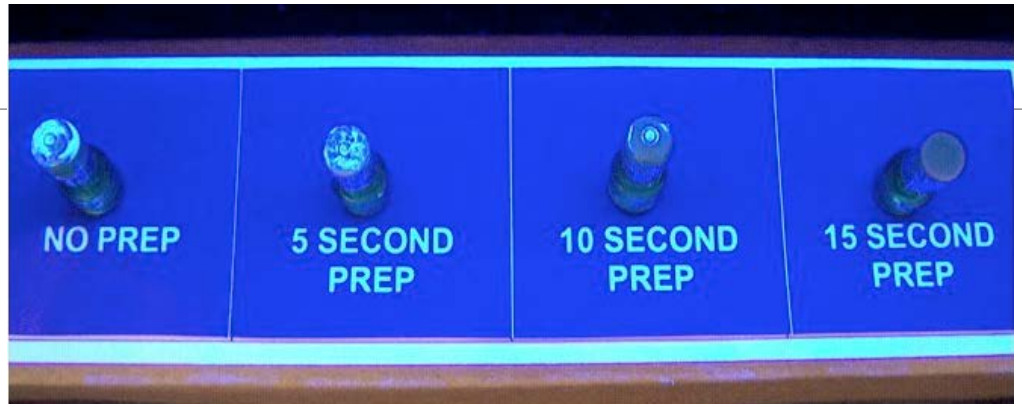
[ ] Hand Hygiene

[ ] Mask, cap, gown, sterile gloves, full body drape

[ ] CHG-alcohol skin antisepsis

[ ] Optimal line site selection

CLABSI: MAINTENANCE



http://allnurses.com/general-nursing-discussion/scrub-the-hub-926648-page5.html

Ensure appropriate nurse-to-patient ratio and limit the use of float nurses in the ICU {I}

Disinfect catheter hubs, needleless connectors, and injection ports before accessing the catheter {II}

Remove nonessential catheters {II}

For non-tunneled CVCs in adults and children, change transparent dressings and perform site care with a CHG-based antiseptic every 5-7 days or immediately if dressing is soiled, loose or damp {II}

Replace administration sets not used for blood, blood products, or lipids at intervals not longer than 96 hours {II}

PREVENTING CLABSI: SPECIAL APPROACHES

Use antiseptic or antimicrobial-impregnated CVCs in adult patients {I} in specific situations:

- Higher than desired CLABSI rate
- Patients with recurrent CLABSI
- Patients at higher risk of severe sequelae from a CLABSI (e.g. prosthetic valves)

Use an antiseptic-containing dressing for CVCs inpatients over 2 mo of age {I}

Use an antiseptic-containing hub/connector cap/port protector to cover connectors {I}

Use antimicrobial locks for CVCs {I} in specific situations:

- HD catheters
- Limited access and history of recurrent CLABSI
- Patients at higher risk of severe sequelae from a CLABSI

AVOID:

- Antimicrobial prophylaxis
- Routine replacement of CVCs

PREVENTING CLABSI: UNRESOLVED ISSUES

Routine use of needleless connectors

IV therapy teams

- PICC teams have been shown to reduce BSI (but unknown in CLABSI, specifically)

Silver-coated catheter connectors

Standard transparent dressings (nonantimicrobial)

Impact of CHG-containing products on CHG-resistance

Central Line Associated BSI: High Stakes

CLABSI is a rare event. Every case is examined for root cause.

Public reporting is the rule

- https://www.medicare.gov/hospitalcompare/

Financial penalties for CLABSI are a reality (since 2008) and increasing with VBP.

Reputation may be affected.

2015: Required CLABSI reporting is house-wide (adult and pediatric ICUs, medical, surgical wards)

Standardized Infection Ratio (SIR)

Observed N CLABSI / Predicted N CLABSI

SIR >1 rate is higher than comparator

SIR <1 rate is lower than comparator

If predicted <1 then no SIR is calculated

Regression modeling used to calculate "Predicted" based on NHSN reference population

- 2015 SIRs based on 2006-2008 NHSN baseline
- 2016 SIR "re-baseline" based on 2015 NHSN population

Adjustment factors for CLABSI SIR: location/unit type, bed size, medical school affiliation, facility type (e.g. children/women's hospital), birthweight if NICU

$$SIR = \frac{Observed\ (O)\ HAIs}{Predicted\ (P)\ HAIs}$$

https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf

1. CLABSI in Adult/Pediatric ICUs

North Carolina 2015 CLABSI Highlights in Adult/Pediatric Medical, Surgical and Medical/Surgical Wards & ICUs

- North Carolina hospitals reported 626 infections, compared to the predicted 1104 infections.
  - This was better than the 2006-2008 national experience.
  - This number is larger than the number of CLABSIs reported in previous years.
- CLABSI surveillance was expanded to include medical, surgical and medical/surgical wards. In previous years, surveillance was limited only to adult and pediatric ICUs.
- In 2015, North Carolina did not meet the U.S. Department of Health and Human Services goal to reduce CLABSIs by 50% from the 2006-2008 baseline experience.
- The most commonly identified organisms from adult and pediatric CLABSI patients were *Candida* and other yeasts/fungi.

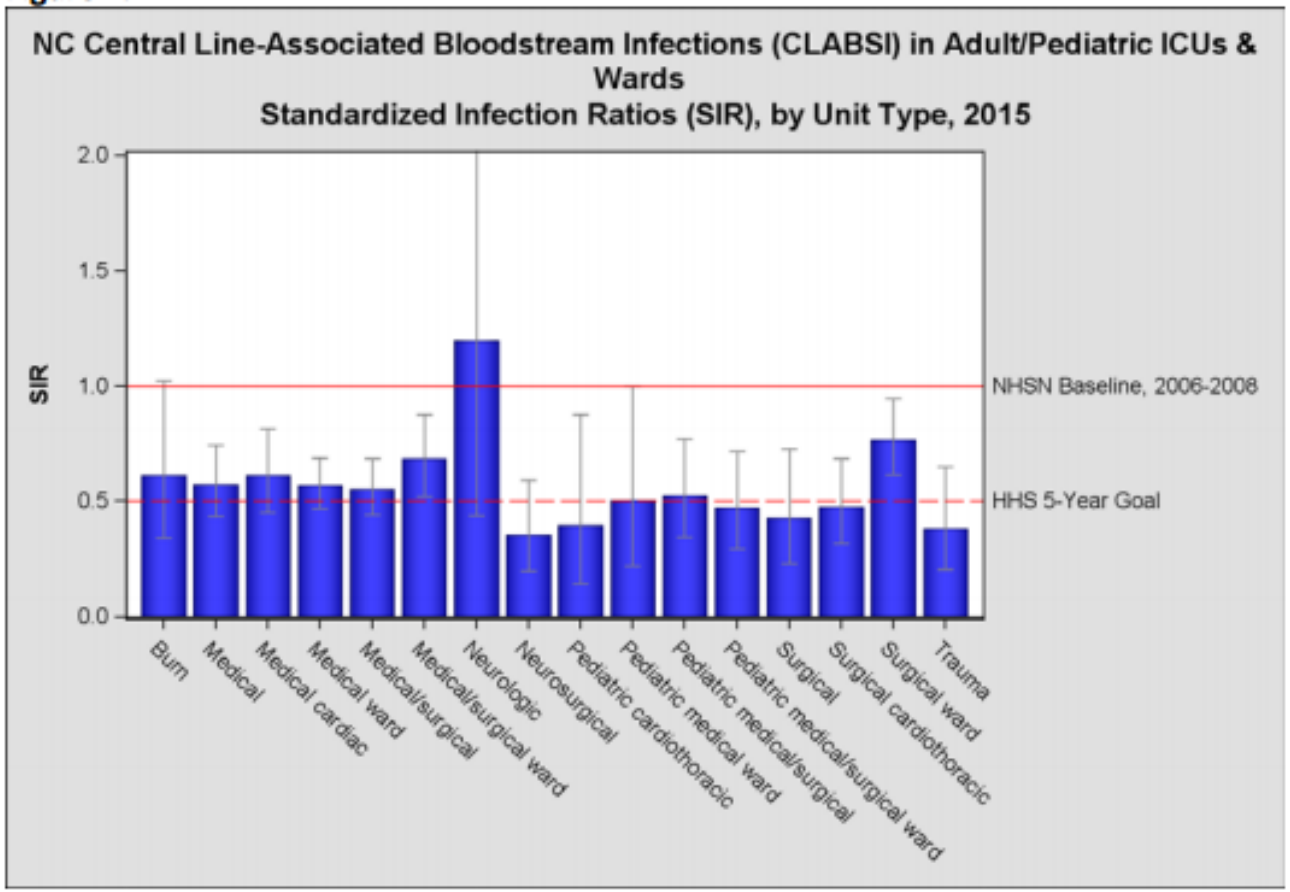
Table 1. N.C. Central Line Associated Bloodstream Infections (CLABSI) in Adult/Pediatric Medical, Surgical and Medical/Surgical Wards & ICUs, by Year, 2012-2015

Year	# Observed Infections	# Predicted Infections	How Does North Carolina Compare to the National Experience?
2012	310	637	★Better: Fewer infections than were predicted (better than the national experience)
2013	315	613	★Better: Fewer infections than were predicted (better than the national experience)
2014	248	644	★Better: Fewer infections than were predicted (better than the national experience)
2015*	626	1104	★Better: Fewer infections than were predicted (better than the national experience)

*In 2015, CLABSI surveillance was expanded to include medical, surgical and medical/surgical wards.

http://epi.publichealth.nc.gov/cd/hai/figures.html

Figure 2.

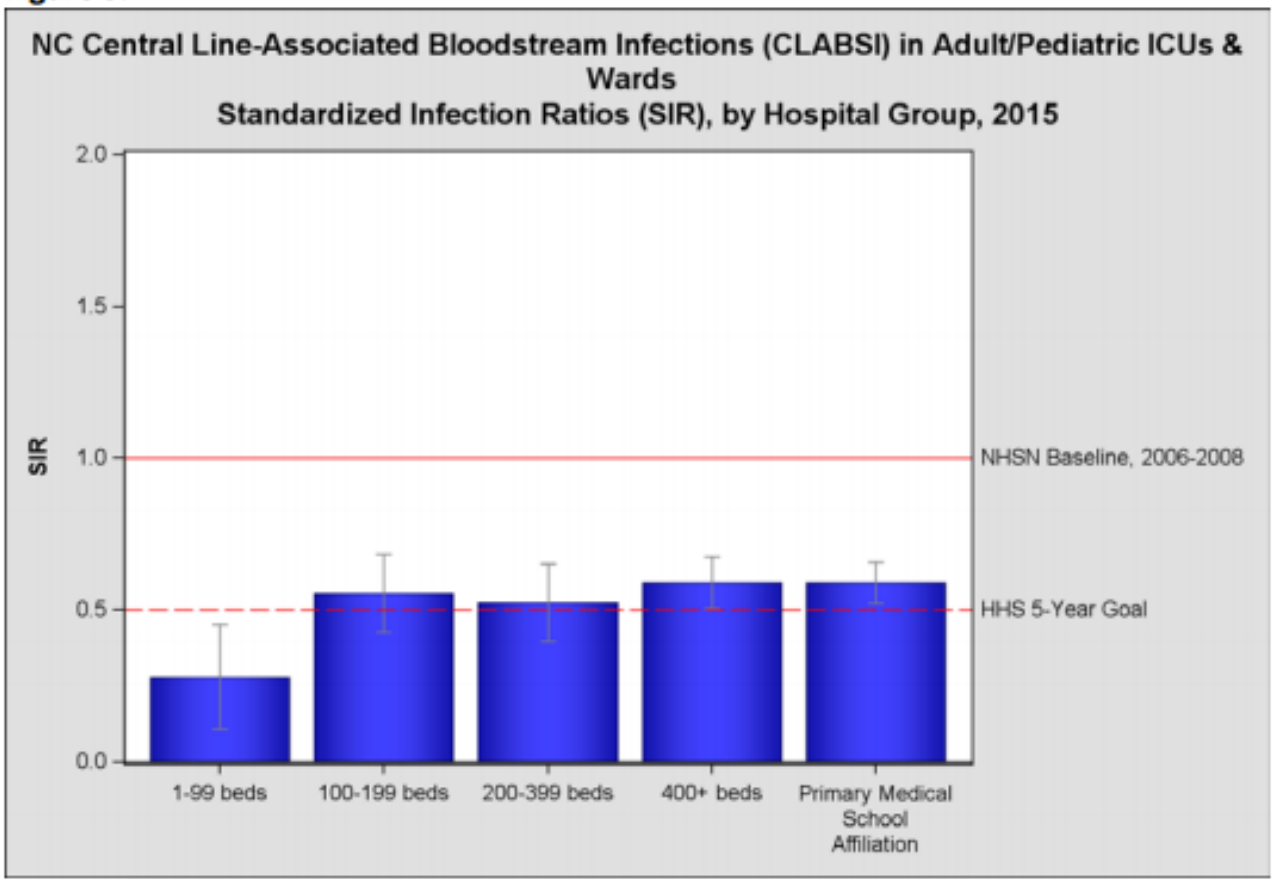


How to Understand Figure 2:

- In 2015, neurologic ICUs had the highest number of observed infections, performing WORSE than predicted by the national experience
- In 2015, all adult/pediatric reporting locations except neurologic ICUs and burn ICUs did BETTER when compared to the national experience
- The number of observed infections in nine of the 16 unit types was higher than the HHS 5-year goal

http://epi.publichealth.nc.gov/cd/hai/figures.html

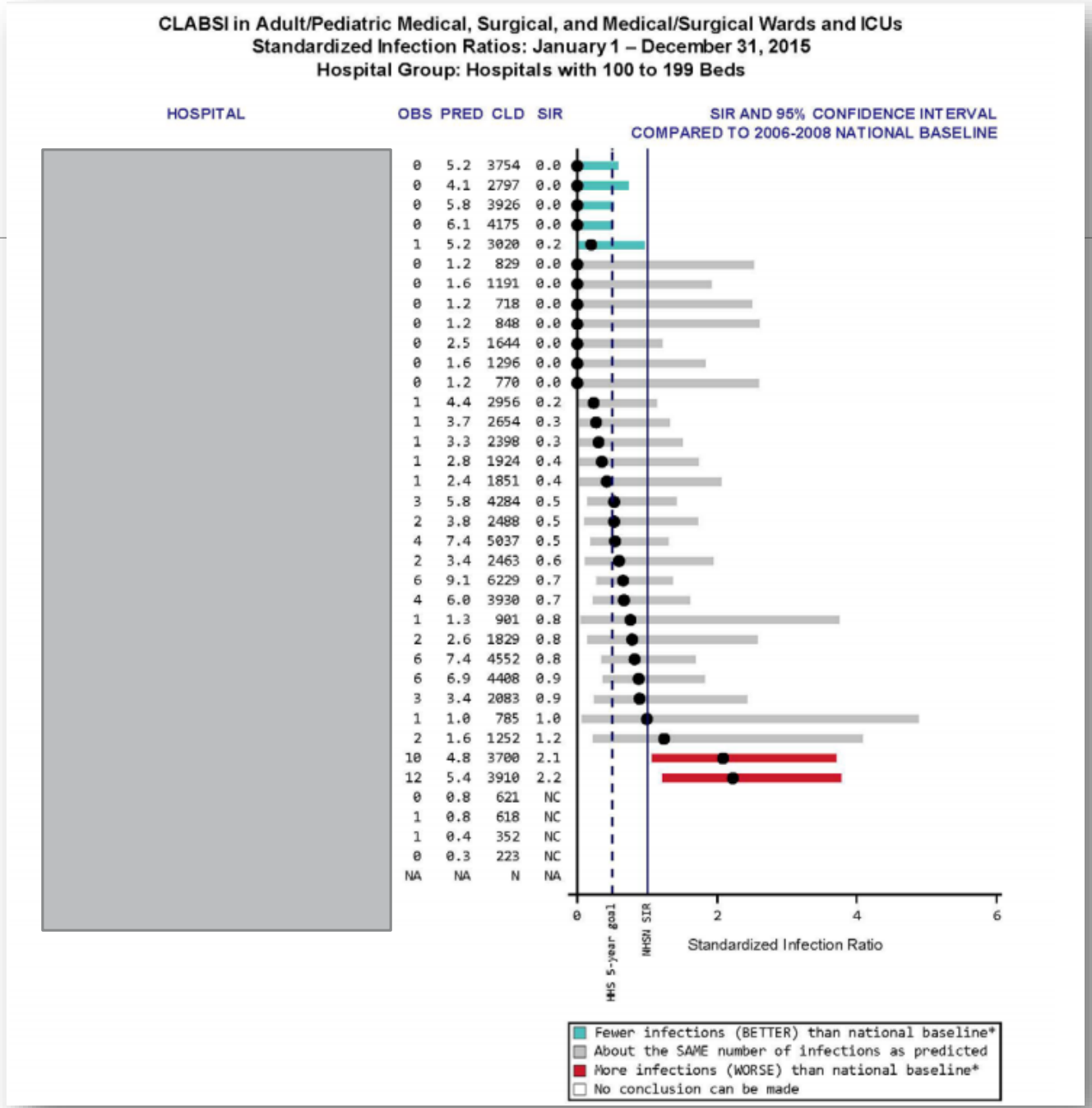
Figure 3.



How to Understand Figure 3:

- In 2015 all hospital groups had fewer observed infections than predicted and did BETTER compared to the national experience
- Hospitals with less than 100 beds were the only hospital size group that met the targeted HHS 5-year goal

http://epi.publichealth.nc.gov/cd/hai/figures.html



http://epi.publichealth.nc.gov/cd/hai/figures.html

IC effect on primary BSI

The Effect of a Nationwide Infection Control Program Expansion on Hospital-Onset Gram-Negative Rod Bacteremia in 130 Veterans Health Administration Medical Centers: An Interrupted Time-Series Analysis

Michihiko Goto,[1,2] Amy M. J. O'Shea,[1,2] Daniel J. Livorsi,[1,2] Jennifer S. McDanel,[1,2] Makoto M. Jones,[3,4] Kelly K. Richardson,[1] Brice F. Beck,[1] Bruce Alexander,[1] Martin E. Evans,[5,6,7] Gary A. Roselle,[8,9,10] Stephen M. Kralovic,[8,9,10] and Eli N. Perencevich[1,2]

[1]Iowa City Veterans Affairs (VA) Health Care System, and [2]University of Iowa Carver College of Medicine, Iowa City; [3]Salt Lake City VA Health Care System, and [4]University of Utah School of Medicine, Salt Lake City; [5]Veterans Health Administration (VHA) MDRO Program Office, [6]Lexington VA Medical Center, and [7]University of Kentucky College of Medicine, Lexington; [8]VHA National Infectious Diseases Service, [9]Cincinnati VA Medical Center, and [10]University of Cincinnati College of Medicine, Ohio

Horizontal

- Local MDRO coordinator
- Culture transformation
- Education
- Leadership

Vertical (MRSA+ only)

- Active surveillance
- Contact precautions

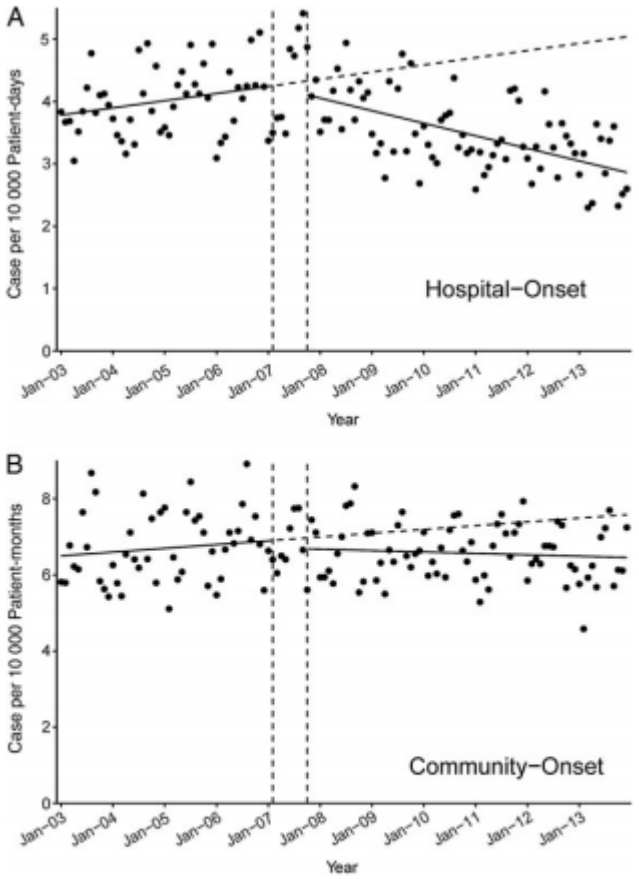


Figure 1. Effect of the Methicillin-Resistant *Staphylococcus aureus* Prevention Initiative on changes in incidence rates of gram-negative rod bacteremia. Solid slope lines are slopes estimated by autoregressive models; break slope lines are estimated slopes without effects of intervention; vertical break lines are beginning and end of implementation of the initiative.

CID. 2016; 63 (5):642-50.

CONCLUSIONS

- Healthcare-associated bloodstream (BSI) cause significant morbidity and mortality
- The most important risk factor for BSI is presence of a central venous catheter
- Clinical definition and surveillance definition of catheter-related BSI are NOT the same
- A near 0 rate of CLABSI is possible using existing technology and appropriate practice strategies
- Current guidelines should be followed for the prevention of CLABSI

Key References

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