# BLOODSTREAM INFECTIONS (BSI)

EPIDEMIOLOGY, PATHOPHYSIOLOGY, AND PREVENTION

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## Disclosures

None

## Objectives

Understand the impact of bloodstream infections

Understand the incidence and causative pathogens of bloodstream infections

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

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[6]

| Type of acute care hospital location | No. of locations[1] | Central line days | Patient days | Pooled mean | Percentile 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 | 293,899 | 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 | | | | | | | |
| Trauma | 147 | 329,688 | | | | | | | |
| Step-down units | | | | | | | | | |
| Adult step-down (postcritical care) | 700 (699) | 818,478 | | | | | | | |
| 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[7] | | | | | | | | | |
| 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 | | | | | | | | | |

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

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[6] Type of acute care hospital location | No. of locations[1] | No. of CLABSIs | Central line days | Pooled mean | Percentile 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) | 1,037 | 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 | 43 | 185 | 146,328 | 1.3 | 0.0 | 0.5 | 1.3 | 2.0 | 2.7 |
| Pediatric medical | | | | | | | | | |
| Pediatric medical/surgical | | | | | | | | | |
| Pediatric surgical | | | | | | | | | |
| Prenatal | | | | | | | | | |
| Respiratory | | | | | | | | | |
| Surgical: major teaching | | | | | | | | | |
| Surgical: all other | 195 (189) | 235 | 345,261 | 0.9 | 0.0 | 0.0 | 0.7 | 1.4 | 2.3 |
| 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 |

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

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 diagnostic testing

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

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 bacteremic episodes 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

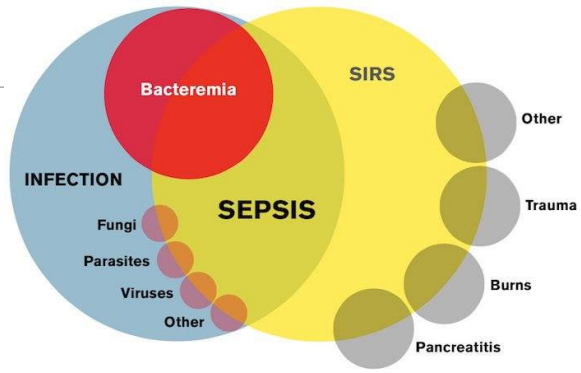
Respiratory: hyperventilation → respiratory failure

Neurologic: Confusion → seizure, coma

Secondary: Other localized infection symptoms

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



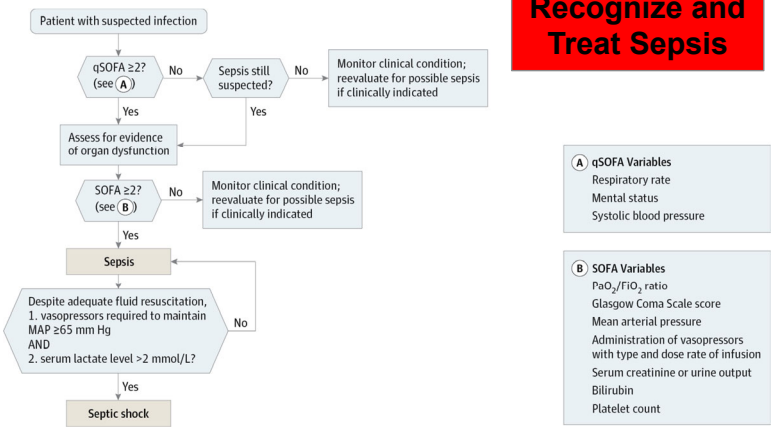



SIRS criteria (old):
WBC>12K or <4K or >10% bands
RR>20
HR>90
Temp>38 or <36C

Image: https://twitter.com/ICPIC_meeting/status/982198791301283842



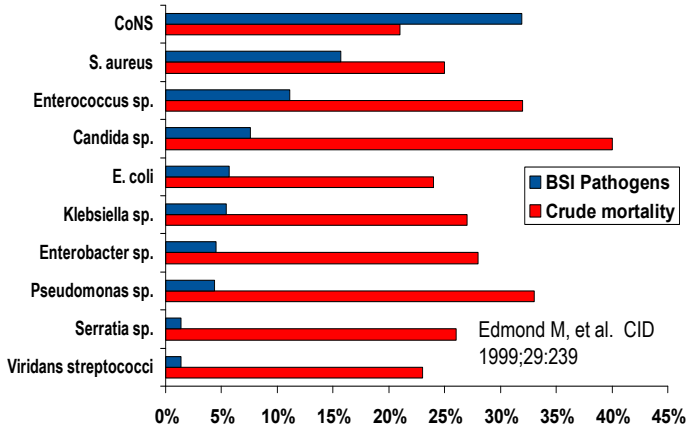
## Recognize and Treat Sepsis




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



# MORTALITY OF NOSOCOMIAL BSI, SCOPE, 1995-98




Edmond M, et al. CID 1999;29:239

# 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

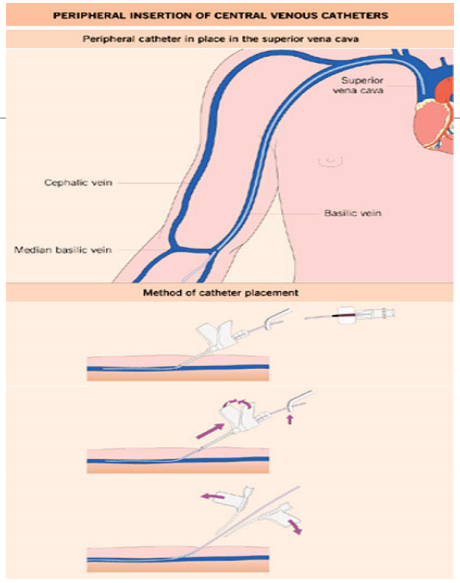
# Central Venous Catheter Infections

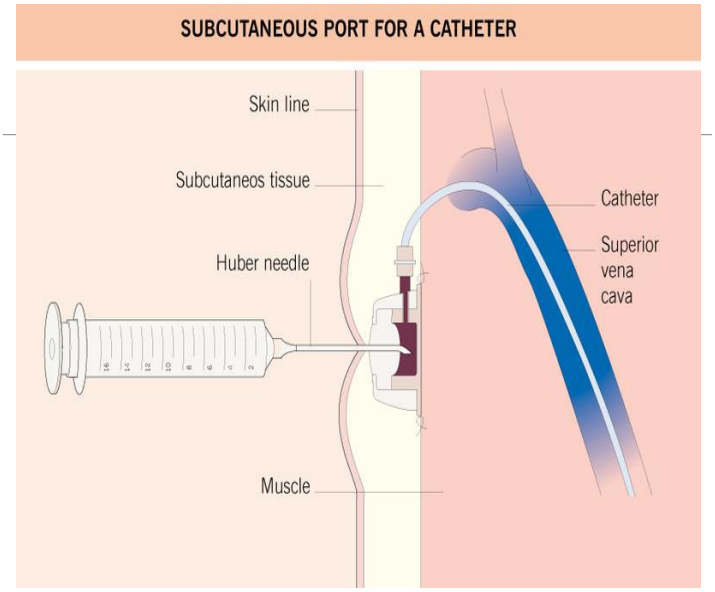
| Infection | Definition |
|---|---|
| Catheter colonization | Significant growth of ≥1 microorganism in a quantitative or semiquantitative culture of the catheter tip, subcutaneous catheter segment, or catheter hub |
| Phlebitis | Induration or erythema, warmth, and pain or tenderness along the tract 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 |



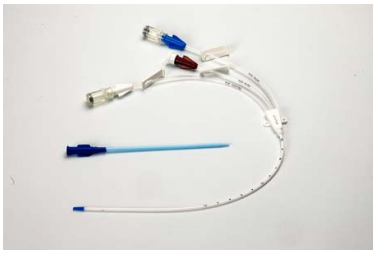

## PATHOGENESIS Central Line Infection

Multifactorial and complex

Most catheter-related infections appear to result from 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



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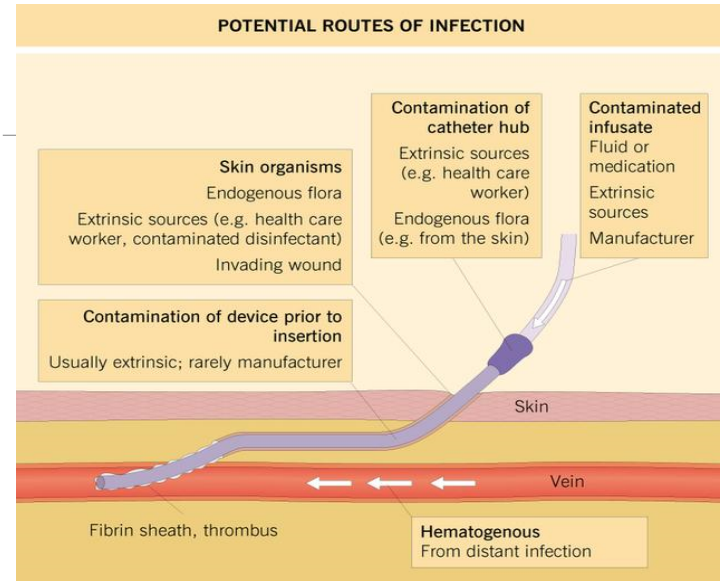
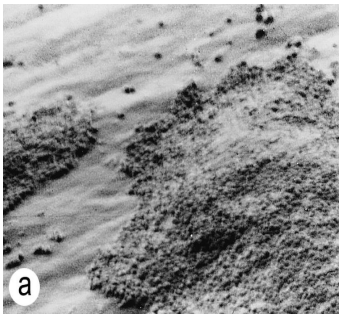
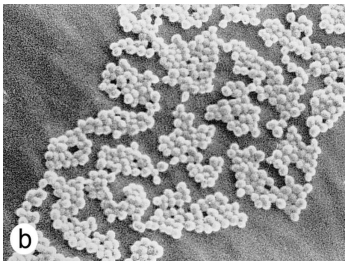
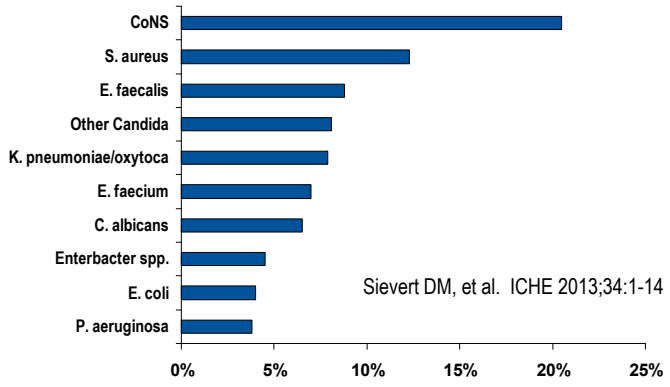



## BIOFILM



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




# 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*

- 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)
- Multilumen or concurrent catheters
- Substandard catheter care
- Neutropenia
- BMA >40
- Prematurity
- Host Immunity: Neutropenia, neonate prematurity
- Reduced Nurse: Patient Ratios (ICU)
- TPN
- Substandard catheter care (e.g. excessive manipulation)
- Blood products (children)

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



# Decreased Risk/Protective Factors

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



# 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*



# COMPLICATIONS OF CLABSIs

## Local infection

- Tunnel infection, pocket infection

## Sepsis

## Remote site infection

- Osteomyelitis
- Meningitis

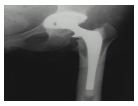
## Endovascular infection

- Endocarditis
- Mycotic aneurysms
- Septic thrombophlebitis

# Identifying Complicated SAB

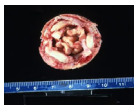
## Clinical Context Matters

## *S. aureus* Bacteremia + Prosthesis = Trouble



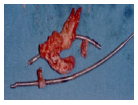
SAB + Arthroplasty = 28% Joint Infection

Murdoch et al *Clin Infect Dis* 2001; 32:647-9.



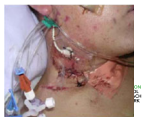
SAB + Prosthetic Valve = 51% Valve Infection

El-Adhab *Am J Med* 2005; 118:225-9.



SAB + Pacemaker/ICD = 45% Device Infection

Chamis *Circulation* 2001; 104: 1029



SAB + Central Catheter = 71% Thrombophlebitis

Crowley *Crit Care Med* 2008;36:385-90

Slide: Thomas Holland MD, Duke Univ



# 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.

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



SURVEILLANCE DEFINITION

# What is BSI?

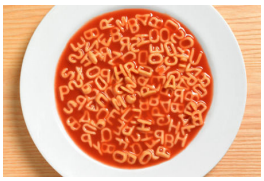
There are multiple surveillance definitions to be familiar with for BSI:

LCBI (1 to 3)

Secondary BSI due to other site-specific infection

MBI LCBI (1 to 3)

CLABSI



https://www.cdc.gov/nhsn/pdfs/pscmanual/4psc_clabscurrent.pdf



SURVEILLANCE DEFINITION

# Healthcare Associated Infection (HAI)

There are multiple "timing" related definitions:

- Date of Event (DOE)
- Healthcare associated infection (HAI)
- Infection window period (IWP)
- Present on admission (POA)
- Repeat infection timeframe (RIT)
- Secondary BSI attribution period (SBAP) = IWP + RIT

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.



SURVEILLANCE DEFINITION

# Laboratory Confirmed BSI (LCBI)

Must meet ONE of 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

# LCBI 1

1

Patient of any age has a recognized pathogen, which is an organism NOT included on the NHSN common commensal list, identified from one or more blood specimens obtained by a culture or non-culture based microbiologic testing method

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

# LCBI 2

2

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

AND

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

AND

The same NHSN common commensal is identified by a culture or non-culture based microbiologic testing method, from two or more blood specimens collected on separate occasions.

Criterion elements must occur within the Infection Window Period (IWP), 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.*
*Rhodococcus spp.*



SURVEILLANCE DEFINITION

# LCBI 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 NHSN common commensal is identified by a culture or non-culture based microbiologic testing method, from two or more blood specimens collected on separate occasions.

Criterion elements must occur within the Infection Window Period (IWP), 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.*
*Rhodococcus spp.*



SURVEILLANCE DEFINITION

# Secondary BSI

An NHSN site-specific definition must be met; either one of the CDC/NHSN Surveillance Definitions for Specific Types of Infections (defined in Chapter 17), or UTI, PNEU or SSI definitions.

AND

One of the following scenarios must be met:

| Scenario 1 | Scenario 2 |
|---|---|
| A positive blood specimen must contain at least **one eligible matching organism** to the site-specific specimen | Positive blood specimen must be an **element** of the **site-specific definition** |
| **And the blood** specimen is collected in the site-specific **secondary BSI attribution period** | **And** blood specimen is collected in the site-specific **infection window period** |
| And an eligible organism **identified from the site-specific specimen** is used as an element to meet the site-specific definition | And an eligible organism **identified in a blood specimen** is used as an element to meet the site-specific definition |

Scenario 1 "Match"

Scenario 2 "Element"



**Table 1: CDC/NHSN Major and Specific Types of Infections**

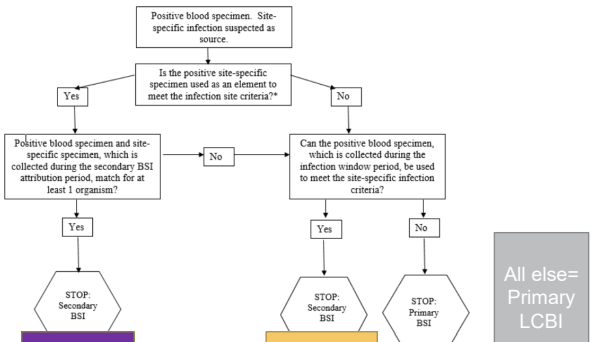
| Type |
|---|
| **BJ – Bone and Joint Infection** |
| BONE – Osteomyelitis |
| DISC – Disc space infection |
| JNT – Joint or bursa infection |
| PJI – Prosthetic joint infection |
| **CNS – Central Nervous System** |
| IC – Intracranial infection |
| MEN – Meningitis or ventriculitis |
| SA – Spinal abscess without meningitis |
| **CVS – Cardiovascular System Infection** |
| CARD – Myocarditis or pericarditis |
| ENDO – Endocarditis |
| MED – Mediastinitis |
| VASC – Arterial or venous infection |
| **EENT – Eye, Ear, Nose, Throat, or Mouth Infection** |
| CONJ – Conjunctivitis |
| EAR – Ear, mastoid infection |
| EYE – Eye infection, other than conjunctivitis |
| ORAL – Oral cavity infection (mouth, tongue, or gums) |
| SINU – Sinusitis |
| UR – Upper respiratory tract infection, pharyngitis, laryngitis, epiglottitis |
| **GI – Gastrointestinal System Infection** |
| CDI-*Clostridium difficile* Infection |
| GE – Gastroenteritis |
| GIT – Gastrointestinal (GI) tract infection |
| IAB – Intraabdominal infection, not specified elsewhere |
| NEC – Necrotizing enterocolitis |
| **LRI – Lower Respiratory System Infection, Other Than Pneumonia** |
| LUNG – Other infection of the lower respiratory tract |
| **REPR – Reproductive Tract Infection** |
| EMET – Endometritis |
| EPIS – Episiotomy infection |
| OREP – Other infection of the male or female reproductive tract |
| VCUF – Vaginal cuff infection |

| **SST-Skin and Soft Tissue Infection** |
|---|
| BRST – Breast abscess or mastitis |
| BURN – Burn Infection |
| CIRC – Newborn circumcision infection |
| DECU – Decubitus ulcer infection (also known as pressure injury infection) |
| SKIN – Skin infection |
| ST – Soft tissue infection |
| UMB – Omphalitis |
| **USI – Urinary System Infection** |

| Site | Criterion |
|---|---|
| BONE | 3a |
| BURN | 1 |
| DISC | 3a |
| ENDO | 4a, 4b, 5a or 5b (specific organisms) 6e or 7e plus other criteria as listed |
| GIT | 1b or 2c |
| IAB | 2b or 3b |
| JNT | 3c |
| MEN | 2c or 3c |
| OREP | 3a |
| PNEU | 2 or 3 |
| SA | 3a |
| UMB | 1b |
| USI | 3b or 4b |



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




Scenario 1 "Match"

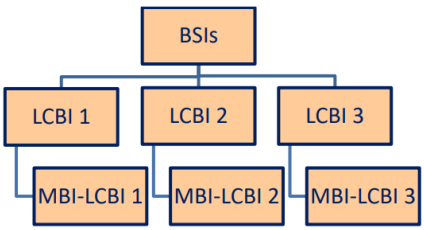
Scenario 2 "Element"



SURVEILLANCE DEFINITION

# Laboratory Confirmed BSI (LCBI)

**LCBI Hierarchy; Types of LCBIs (see Table 1 and Table 2):**



# Hem/Onc/BMT a "special population" for surveillance

| | |
|---|---|
| Complex patient population | • Highly toxic treatments<br>• ICU stays<br>• Complications (infection, bleeding, ADEs) |
| Device utilization | • True need for central line |
| Culturing practices | • Bad veins<br>• Thrombocytopenia |
| Antimicrobial utilization | • Like water<br>• 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<br>• Definitions don't apply well to patient population and leads to rejection of data |



SURVEILLANCE DEFINITION

## Mucosal Barrier Injury Laboratory Confirmed Bloodstream Infection (MBI-LCBI)

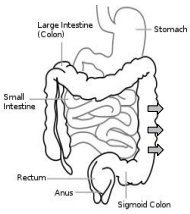
A subset of the LCBI criteria

Aim to identify the "special population" of patients who have BSI due to hematogenous spread from the gut/oral flora due to immune compromise

Must meet one of the 3 LCBI criteria

AND

Must meet one of the two MBI criteria



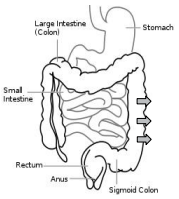


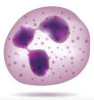

SURVEILLANCE DEFINITION

## Mucosal Barrier Injury Laboratory Confirmed Bloodstream Infection (MBI-LCBI)

One of two MBI criteria:

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:
   a) Grade III or IV gastrointestinal graft versus host disease [GI GVHD]
   b) ≥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 the 7 calendar days before the date the positive blood specimen was collected.
2. Is neutropenic, defined as at least two separate days with ANC and/or WBC values <500 cells/mm3 collected within a 7-day time period which includes the collection date of the positive blood specimen, the 3 calendar days before and the 3 calendar days after.





SURVEILLANCE DEFINITION

## MBI-BSI 1

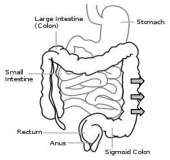
1

LCBI 1 = at least 1 culture positive for "recognized pathogen"

from the intestines

Plus

One of the MBI criteria




**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 2

2

LCBI 2 = signs and symptoms AND at least 2 separate cultures with "common commensals"

Only viridans group Streptococci and/or Rothia spp. and no other organisms.

Plus

One of the two MBI criteria



SURVEILLANCE DEFINITION

## MBI-BSI 3

LCBI 3 = Patient ≤1 year of age, AND at least 2 separate cultures with "common commensals"

Only viridans group streptococci and/or Rothia spp and no other organisms.

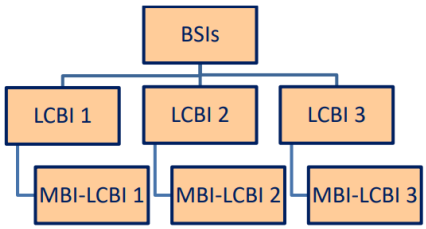
Plus

One of the MBI criteria

SURVEILLANCE DEFINITION

# Laboratory Confirmed BSI (LCBI)

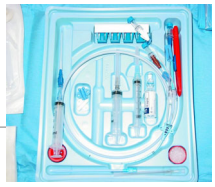
**LCBI Hierarchy; Types of LCBIs (see Table 1 and Table 2):**






SURVEILLANCE DEFINITION

# Central Line



Central line: terminates at or close to the heart or in one of the great vessels, used for infusions, withdrawal of blood, or hemodynamic monitoring.

- 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 dialysis catheters
- Implanted catheters (including ports)

Umbilical catheter: A vascular catheter inserted through the umbilical artery or vein in a neonate.



SURVEILLANCE DEFINITION

# CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI) EVENT

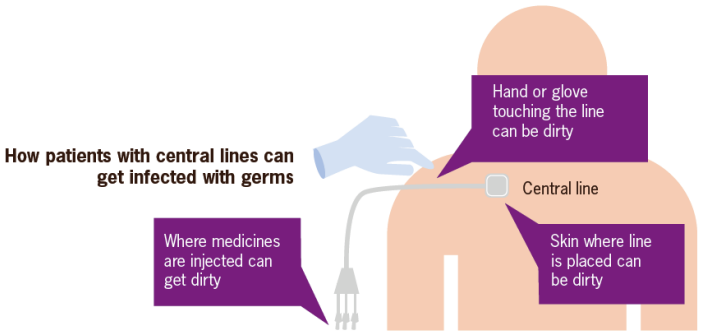
Eligible Central Line: A CL that has been in place for more than two consecutive calendar days (on or after CL day 3), following the first access of the central line, in an inpatient location, during the current admission. Such lines are eligible for CLABSI events and remain eligible for CLABSI events until the day after removal from the body or patient discharge, whichever comes first.

Central line-associated BSI (CLABSI): A laboratory confirmed bloodstream infection where an eligible BSI organism is identified and an eligible central line is present on the LCBI DOE or the day before.

**https://www.cdc.gov/nhsn/pdfs/pscmanual/4psc_clabscurrent.pdf**



# 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

# 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



*Infection Control & Hospital Epidemiology* (2022), 1–17
doi:10.1017/ice.2022.87

SHEA

**SHEA/IDSA/APIC Practice Recommendation**

## Strategies to prevent central line-associated bloodstream infections in acute-care hospitals: 2022 Update

Niccolò Buetti MD, MSc, PhD[1,2,a], Jonas Marschall MD, MSc[3,4,a], Marci Drees MD, MS[5,6], Mohamad G. Fakih MD, MPH[7], Lynn Hadaway MEd, RN, NPD-BC, CRNI[8], Lisa L. Maragakis MD, MPH[9], Elizabeth Monsees PhD, MBA, RN, CIC[10,11], Shannon Novosad MD MPH[12], Naomi P. O'Grady MD[13], Mark E. Rupp MD[14], Joshua Wolf MBBS, PhD, FRACP[15,16], Deborah Yokoe MD, MPH[17] and Leonard A. Mermel DO, ScM[18,19]

# GRADING THE QUALITY OF EVIDENCE

| Category | Definition |
|---|---|
| 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 are a wide range of studies with no major limitations, there is little variation between studies, and the summary estimate has a narrow confidence interval. |
| 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, and/or the confidence interval of the summary estimate is wide. |
| 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, and/or there are no rigorous studies. |

[a]Based on the CDC Healthcare Infection Control Practices Advisory Committee (HICPAC) "Update to the Centers for Disease Control and Prevention and the Healthcare Infection Control Practices Advisory Committee Recommendations Categorization Scheme for Infection Control and Prevention Guideline Recommendations" (October 2019), the Grades of Recommendation, Assessment, Development, and Evaluation (GRADE),[285] and the Canadian Task Force on Preventive Health Care.[286]



# PREVENTING CLABSI: BEFORE INSERTION

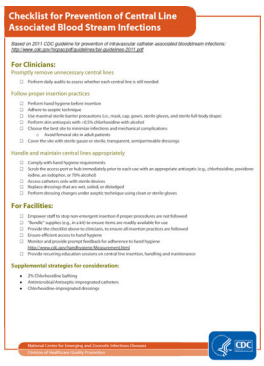
Provide easy access to an evidence-based list of indications for CVC {Low}

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

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



# CDC EDUCATIONAL MATERIAL


Checklist for Prevention of Central Line Associated Blood Stream Infections


FAQs about "Catheter-Associated Bloodstream Infections"

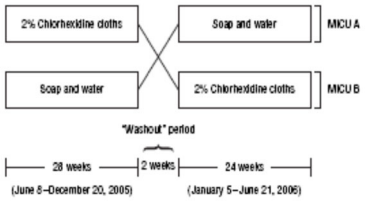
http://www.cdc.gov/HAI/bsi/bsi.html

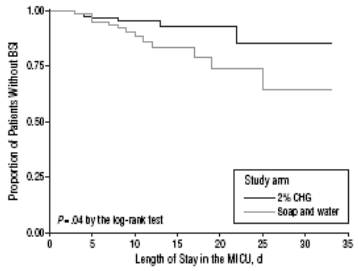
# BATHE ICU PATIENTS >2 MONTHS OF AGE WITH A CHG PREPARATION DAILY

**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

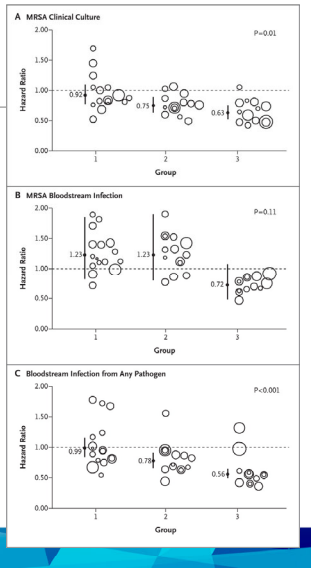
Cluster-randomized trial in 74 ICUs

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.



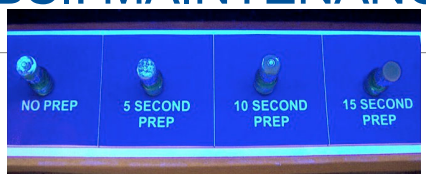

Huang SS et al. N Engl J Med 2013;368:2255-2265.

# PREVENTING CLABSI: AT INSERTION

- Have a process in place to ensure adherence to infection prevention practices (e.g., checklist){Moderate}
- Perform hand hygiene prior to catheter insertion or manipulation {Moderate}
- Subclavian site is preferred in the ICU setting/Avoid using the femoral artery for central venous access in obese patients {High}
  - 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 {Moderate}
- Use ultrasound guidance for internal jugular insertion {High}
- Use maximum sterile barrier precautions during CVC insertion (mask, cap, sterile gown, and sterile gloves; patient covered with full body sterile drape) {Moderate}
- Use alcohol-chlorhexidine for skin antisepsis {High}

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 {High}
- Use CHG-containing dressgings for CVCs in patients > 2 months {High}
- Disinfect catheter hubs, needleless connectors, and injection ports before accessing the catheter {Moderate}
- Remove nonessential catheters {Moderate}
- For non-tunneled CVCs, change dressings and performs site care with CHG-based antiseptic q7d or prn damp/loose/soiled dressing. Gauze q2 days or prn damp/loose/soiled dressing {Moderate}
- 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 {High/Moderate} 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 hub/connector cap/port protector to cover connectors {Moderate}

Use recombinant tPA for HD through CVC {High}

Use vascular access teams {Low}

Use antimicrobial locks for CVCs {High} 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
- Silver-coated catheters
- Standard transparent dressings (nonantimicrobial)
- Impact of CHG-containing products on CHG-resistance
- Sutureless securement
- Necessity of manual disinfection of hub/needless connector when antiseptic-caps used

# 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



## A. Central Line-Associated Bloodstream Infections (CLABSI)

### 1. CLABSI in Adult/Pediatric ICUs and Wards

**North Carolina 2021 CLABSI Highlights in Adult/Pediatric Medical, Surgical, and Medical/Surgical Wards & ICUs**

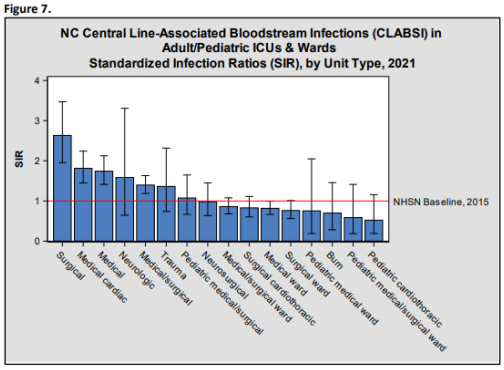
- North Carolina hospitals reported 706 infections, compared to the 616.34 infections predicted by the national experience; this was worse than the 2015 national experience.
- The most commonly identified organisms from adult and pediatric CLABSI patients were *Candida* and other yeasts/fungi, followed by coagulase-negative *Staphylococcus*.

**Table 1. NC Central Line Associated Bloodstream Infections (CLABSI) in Adult/Pediatric Medical, Surgical and Medical/Surgical Wards & ICUs, 2021**

| Year | # Observed Infections | # Predicted Infections | How Does North Carolina Compare to the National Experience? |
|---|---|---|---|
| 2021 | 706 | 616.34 | ✖ WORSE: more than the number of infections predicted (worse than the national experience) |

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

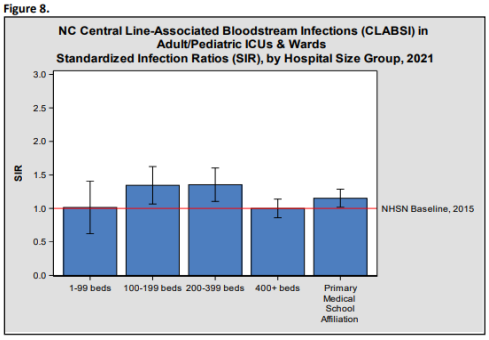
**Figure 7.**




**Interpreting Figure 7:**
- In 2021, medical wards reported fewer infections than predicted, performing BETTER than the national experience
- Surgical, medical cardiac, medical, and medical/surgical ICUs reported more infections than predicted, performing WORSE than the national experience
- All other unit types performed the SAME as the national experience

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

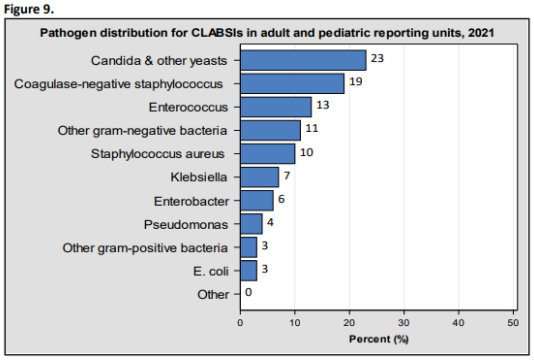
**Figure 8.**




**Interpreting Figure 8:**
- In 2021, hospitals with 100-199 beds, 200-399 beds, and medical school-affiliated hospitals had more CLABSIs than predicted, performing WORSE than the national experience
- All other hospitals observed about the same number of CLABSIs as predicted, performing the SAME as the national experience

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

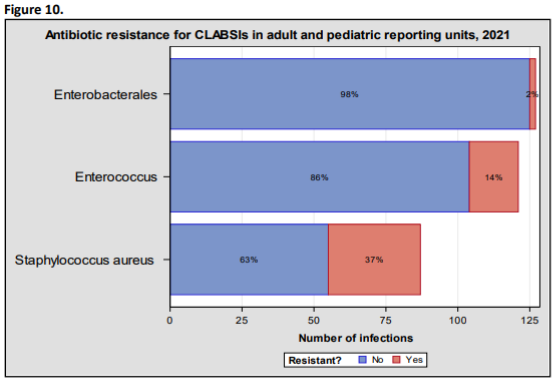
**Figure 9.**




**Interpreting Figure 9:**
- In 2021, The most commonly identified organisms from adult and pediatric CLABSI patients were *Candida* spp. and other yeasts/fungi (23%) followed by coagulase-negative *Staphylococcus* (19%)

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

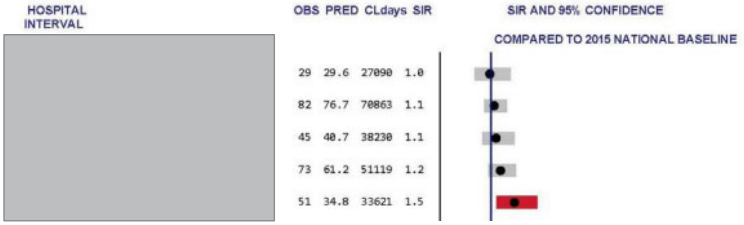
Figure 10.




**Interpreting Figure 10:**

- In 2021, 37% of *Staphylococcus aureus* identified among adult/pediatric CLABSIs were resistant to methicillin.
- 14% of *Enterococcus* identified among adult/pediatric CLABSIs were resistant to vancomycin.
- The percentage of *Enterobacterales* identified among adult/pediatric CLABSIs resistant to carbapenems is low (2%).

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

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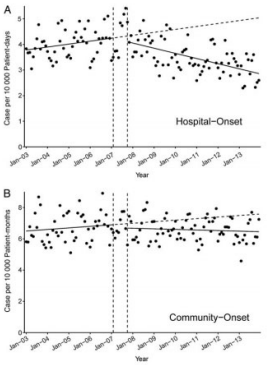


**Figure 1.** Effect of the Methicillin-Resistant *Staphylococcus aureus* Prevention Initiative on changes in incidence rates of gram-negative rod bacteremia. Solid slope lines are slopes estimated by autoregressive models; break slope lines are estimated slopes without effects of intervention; vertical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

## Horizontal

- Local MDRO coordinator
- Culture transformation
- Education
- Leadership

## Vertical (MRSA+ only)

- Active surveillance
- Contact precautions

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

# CLABSI Prevention Success!

In 2017, there were 24,265 CLABSIs reported by 3576 United States acute care hospitals to the United States Centers for Disease Control and Prevention's National Healthcare Safety Network

**-19%**

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

United States Centers for Disease Control and Prevention. Current HAI Progress Report. https://www.cdc.gov/hai/data/portal/progress-report.html
MMWR Morb Mortal Wkly Rep. 2011;60(8):243.



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

**Nationally, among acute care hospitals, the 2021 annual highlights in this report include:**

- Overall, 7% increase in CLABSI between 2020 and 2021
  - Largest increase in ICUs (10%)

https://www.cdc.gov/hai/data/portal/progress-report.html

# 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


Clinical Management of catheter-related infections.

- *Clinical Infectious Diseases*; 2009; 49: 1-45.

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SHEA Compendium: Strategies to Prevent CLABSI.

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