



Central Line-Associated Bloodstream Infection (CLABSI) Event

Introduction: An estimated 248,000 bloodstream infections occur in U.S. hospitals each year¹. It is believed that a large proportion of these are associated with the presence of a central vascular catheter, though this is an area where more study is needed. For the purposes of NHSN, such infections are termed central line-associated bloodstream infections (CLABSI). Bloodstream infections are usually serious infections typically causing a prolongation of hospital stay and increased cost and risk of mortality.

CLABSI can be prevented through proper management of the central line. These techniques are addressed in the CDC's Healthcare Infection Control Practices Advisory Committee (CDC/HIPAC) *Guidelines for the Prevention of Intravascular Catheter-Related Infections*².

Settings: Surveillance will occur in any inpatient location where denominator data can be collected, which may include critical/intensive care units (ICU), specialty care areas (SCA), neonatal units, stepdown units, wards, and long term care units.

NOTE: Surveillance for CLABSIs after the patient is discharged from the facility is not required, however, if discovered, these infections should be reported to NHSN. No additional central line days are reported.

Requirements: Surveillance for CLABSI in at least one inpatient location in the healthcare institution for at least one calendar month as indicated in the *Patient Safety Monthly Reporting Plan* (CDC 57.106).

Definitions:

Primary bloodstream infections (BSI) are laboratory-confirmed bloodstream infections (LCBI) that are not secondary to an infection meeting CDC/NHSN criteria at another body site (see criteria in Chapter 17 CDC/NHSN Surveillance Definition. Report BSIs that are central line-associated (i.e., a central line or umbilical catheter was in place at the time of, or within 48 hours before, onset of the event).

NOTE: There is no minimum period of time that the central line must be in place in order for the BSI to be considered central line-associated.

Location of attribution: The location where the patient was assigned on the date of the BSI event, which is further defined as the date when the first clinical evidence appeared or the date the specimen used to meet the BSI criteria was collected, whichever came first.

EXAMPLE: Patient has a central line inserted in the Emergency Department and then is admitted to the MICU. Within 24 hours of admission to the MICU, patient meets criteria for BSI. This is reported to NHSN as a CLABSI for the MICU, because the Emergency Department is not an inpatient location and no denominator data are collected there.



EXAMPLE: Patient on the urology ward of Hospital A had the central line removed and is discharged home a few hours later. The IP from Hospital B calls the next day to report that this patient has been admitted to Hospital B with a BSI. This CLABSI should be reported to NHSN for, and by, Hospital A and attributed to the urology ward. No additional catheter days are reported.

EXCEPTION: If a CLABSI develops within 48 hours of transfer from one inpatient location to another in the same facility, the infection is attributed to the transferring location. This is called the Transfer Rule and examples are shown below:

- Patient with a central line in place in the SICU is transferred to the surgical ward. Thirty six (36) hours later, the patient meets the criteria for BSI. This is reported to NHSN as a CLABSI for the SICU.
- Patient is transferred to the medical ward from the MSICU after having the central line removed. Within 24 hours, patient meets criteria for a BSI. This is reported to NHSN as a CLABSI for the MSICU.
- Patient with a central line in place is transferred from the medical ward to the coronary care ICU (CCU). After 4 days in the CCU, the patient meets the criteria for a BSI. This is reported to NHSN as a CLABSI for the CCU.

Central line: An intravascular catheter that terminates at or close to the heart or in one of the great vessels which is used for infusion, withdrawal of blood, or hemodynamic monitoring. The following are considered great vessels for the purpose of reporting central-line BSI and counting central-line days in the NHSN system: Aorta, pulmonary artery, superior vena cava, inferior vena cava, brachiocephalic veins, internal jugular veins, subclavian veins, external iliac veins, common iliac veins, common femoral veins, and in neonates, the umbilical artery/vein.

NOTE: Neither the insertion site nor the type of device may be used to determine if a line qualifies as a central line. The device must terminate in one of these vessels or in or near the heart to qualify as a central line.

NOTE: An introducer is considered an intravascular catheter.

NOTE: Pacemaker wires and other nonlumened devices inserted into central blood vessels or the heart are not considered central lines, because fluids are not infused, pushed, nor withdrawn through such devices.

Infusion: The introduction of a solution through a blood vessel via a catheter lumen. This may include continuous infusions such as nutritional fluids or medications, or it may include intermittent infusions such as flushes or IV antimicrobial administration, or blood, in the case of transfusion or hemodialysis.

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

Temporary central line: A non-tunneled catheter.

Permanent central line: Includes

- Tunneled catheters, including certain dialysis catheters



- Implanted catheters (including ports)

Laboratory-confirmed bloodstream infection (LCBI): Must meet one of the following criteria:

Criterion 1: Patient has a recognized pathogen cultured from one or more blood cultures
and
organism cultured from blood is not related to an infection at another site. (See Notes 1 and 2 below.)

Criterion 2: Patient has at least one of the following signs or symptoms: fever (>38°C), chills, or hypotension
and
signs and symptoms and positive laboratory results are not related to an infection at another site
and
common skin contaminant (i.e., diphtheroids [*Corynebacterium* spp.], *Bacillus* [not *B. anthracis*] spp., *Propionibacterium* spp., coagulase-negative staphylococci [including *S. epidermidis*], viridans group streptococci, *Aerococcus* spp., *Micrococcus* spp.) is cultured from two or more blood cultures drawn on separate occasions.

Criterion 3: Patient \leq 1 year of age has at least one of the following signs or symptoms: fever (>38°C core) hypothermia (<36°C core), apnea, or bradycardia
and
signs and symptoms and positive laboratory results are not related to an infection at another site
and
common skin contaminant (i.e., diphtheroids [*Corynebacterium* spp.], *Bacillus* [not *B. anthracis*] spp., *Propionibacterium* spp., coagulase-negative staphylococci [including *S. epidermidis*], viridans group streptococci, *Aerococcus* spp., *Micrococcus* spp.) is cultured from two or more blood cultures drawn on separate occasions. (See Notes 3, 4 and 5 below.)

NOTES:

1. In criterion 1, the phrase “one or more blood cultures” means that at least one bottle from a blood draw is reported by the laboratory as having grown organisms (i.e., is a positive blood culture).
2. In criterion 1, the term “recognized pathogen” does not include organisms considered common skin contaminants (see criteria 2 and 3 for a list of common skin contaminants). A few of the recognized pathogens are *S. aureus*, *Enterococcus* spp., *E. coli*, *Pseudomonas* spp., *Klebsiella* spp., *Candida* spp., etc.
3. In criteria 2 and 3, the phrase “two or more blood cultures drawn on separate occasions” means 1) that blood from at least two blood draws were collected within two days of each other (e.g., blood draws on Monday and Tuesday or



Monday and Wednesday would be acceptable for blood cultures drawn on separate occasions, but blood draws on Monday and Thursday would be too far apart in time to meet this criterion), and 2) that at least one bottle from each blood draw is reported by the laboratory as having grown the same common skin contaminant organism (i.e., is a positive blood culture). (See Note 4 for determining sameness of organisms.)

- a. For example, an adult patient has blood drawn at 8 a.m. and again at 8:15 a.m. of the same day. Blood from each blood draw is inoculated into two bottles and incubated (four bottles total). If one bottle from each blood draw set is positive for coagulase-negative staphylococci, this part of the criterion is met.
 - b. For example, a neonate has blood drawn for culture on Tuesday and again on Saturday and both grow the same common skin contaminant. Because the time between these blood cultures exceeds the two-day period for blood draws stipulated in criteria 2 and 3, this part of the criteria is not met.
 - c. A blood culture may consist of a single bottle for a pediatric blood draw due to volume constraints. Therefore, to meet this part of the criterion, each bottle from two or more draws would have to be culture-positive for the same skin contaminant.
4. There are several issues to consider when determining sameness of organisms.
- a. If the common skin contaminant is identified to the species level from one culture, and a companion culture is identified with only a descriptive name (i.e., to the genus level), then it is assumed that the organisms are the same. The speciated organism should be reported as the infecting pathogen (see examples below).

Table 1. Examples of how to report speciated and unspeciated common skin contaminate organisms

Culture Report	Companion Culture Report	Report as...
<i>S. epidermidis</i>	<i>Coagulase-negative staphylococci</i>	<i>S. epidermidis</i>
<i>Bacillus</i> spp. (not <i>anthracis</i>)	<i>B. cereus</i>	<i>B. cereus</i>
<i>S. salivarius</i>	<i>Strep viridans</i>	<i>S. salivarius</i>



Table 2. Examples of how to interpret the sameness of two skin contaminate isolates by comparing antimicrobial susceptibilities

Culture Report	Isolate A	Isolate B	Interpret as...
<i>S. epidermidis</i>	All drugs S	All drugs S	Same
<i>S. epidermidis</i>	OX R GENT R	OX S GENT S	Different
<i>Corynebacterium</i> spp.	PEN G R CIPRO S	PEN G S CIPRO R	Different
<i>Strep viridans</i>	All drugs S	All drugs S except ERYTH (R)	Same

- b. If common skin contaminant organisms from the cultures are speciated but no antibiograms are done or they are done for only one of the isolates, it is assumed that the organisms are the same.
 - c. If the common skin contaminants from the cultures have antibiograms that are different for two or more antimicrobial agents, it is assumed that the organisms are not the same (see Table 2).
 - d. For the purpose of NHSN antibiogram reporting, the category interpretation of intermediate (I) should not be used to distinguish whether two organisms are different.
5. LCBI criteria 1 and 2 may be used for patients of any age, including patients ≤ 1 year of age.
6. Specimen Collection Considerations:
Ideally, blood specimens for culture should be obtained from two to four blood draws from separate venipuncture sites (e.g., right and left antecubital veins), not through a vascular catheter. These blood draws should be performed simultaneously or over a short period of time (i.e., within a few hours).^{3,4} If your facility does not currently obtain specimens using this technique, you may still report BSIs using the criteria and notes above, but you should work with appropriate personnel to facilitate better specimen collection practices for blood cultures.

REPORTING INSTRUCTIONS:

- Purulent phlebitis confirmed with a positive semiquantitative culture of a catheter tip, but with either negative or no blood culture is considered a CVS-VASC, not a BSI.
- Report organisms cultured from blood as BSI – LCBI when no other site of infection is evident.
- Occasionally a patient with both peripheral and central IV lines develops a primary bloodstream infection (LCBI) that can clearly be attributed to the peripheral line (e.g., pus at the insertion site and matching pathogen from pus and blood). In this situation, enter “Central Line = No” in the NHSN application. You should, however, count the patient’s central line days.
- Even if there are clinical signs or symptoms of localized infection at a vascular access site, but no other infection can be found, the infection is considered a primary BSI.



Numerator Data: The *Primary Bloodstream Infection (BSI)* form (CDC 57.108) is used to collect and report each CLABSI that is identified during the month selected for surveillance. The *Instructions for Completion of Primary Bloodstream Infection Form* (Tables of Instructions, Tables 2 and 2a.) contains brief instructions for collection and entry of each data element on the form. The Primary BSI form includes patient demographic information on whether a central line was present, and, if so, the type of central line the patient had as appropriate to the location; these data will be used to calculate line-specific infection rates. Additional data include the specific criteria met for identifying the primary BSI, whether the patient died, the organisms isolated from blood cultures, and the organisms' antimicrobial susceptibilities.

Denominator Data: Device days and patient days are used for denominators (see Chapter 16 Key Terms). Device-day denominator data that are collected differ according to the location of the patients being monitored. For ICUs and locations other than specialty care areas (SCAs) and NICUs, the number of patients with one or more central lines of any type is collected daily, at the same time each day, during the month and recorded on the *Denominators for Intensive Care Unit (ICU)/Other Locations (Not NICU or Specialty Care Area (SCA))* (CDC 57.118). Only the totals for the month are entered into NHSN.

For specialty care areas, the number of patients with one or more central lines is dichotomized into those with permanent central lines and those with temporary central lines on the *Denominators for Specialty Care Area* (CDC 57.117) form. Each is collected daily, at the same time each day. Only the total for the month are entered into NHSN. This distinction in lines is made because permanent lines are commonly used in patients frequenting these areas and may have lower rates of associated infection than central lines inserted for temporary use. If a patient has both a temporary and a permanent central line, count the day only as a temporary line day. The *Instructions for Completion of Denominators for Intensive Care Unit (ICU)/Other Locations form* (Tables of Instructions, Table 6) form and *Instructions for the Completion of Denominators for Specialty Care Areas (SCA) Form* (Tables of Instructions, Table 7) contain brief instructions for collection and entry of each data element on the forms.

In NICUs, again because of differing infection risks, the number of patients with central lines and those with umbilical catheters is collected daily, at the same time each day, during the month. If a patient has both an umbilical catheter and a central line, count the day only as an umbilical catheter day. On the *Denominators for Neonatal Intensive Care Unit (NICU)* (CDC 57.116) form, patients are further stratified by birthweight in five categories since risk of BSI also varies by birthweight.

NOTE: The weight of the infant at the time of BSI is not used and should not be reported. For example, if a neonate weighs 1006 grams at birth but remains in the NICU for two months and has a body weight of 1650 grams when it develops a CLABSI, record



the birthweight of 1006 grams on the BSI form. The *Instructions for Completion of Denominators for Neonatal Intensive Care Unit (NICU) form* (Tables of Instructions, Table 8) contains brief instructions for collection and entry of each data element on the forms.

Data Analyses: The CLABSI rate per 1000 central line days is calculated by dividing the number of CLABSI by the number of central line days and multiplying the result by 1000. The Central Line Utilization Ratio is calculated by dividing the number of central line days by the number of patient days. These calculations will be performed separately for different types of ICUs, specialty care areas, and other locations in the institution. Separate rates and ratios will also be calculated for different types of catheters in specialty care areas and NICUs, and for birthweight categories in NICUs, as appropriate.

¹Klebens RM, Edward JR, et al. Estimating health care-associated infections and deaths in U.S. hospitals, 2002. *Public Health Reports* 2007;122:160-166.

²O'Grady NP, Alexander M, Dellinger EP, Gerberding JL, Heard SO, Maki DG, et al. Guidelines for the prevention of intravascular catheter-related infections. *MMWR* 2002;51(No. RR-10:1-26).

³Clinical and Laboratory Standards Institute (CLSI). *Principles and Procedures for Blood Cultures; Approved Guideline*. CLSI document M47-A (ISBN 1-56238-641-7). Clinical and Laboratory Standards Institute, 940 West Valley Road, Suite 1400, Wayne, Pennsylvania, USA, 2007.

⁴Baron EJ, Weinstein MP, Dunne Jr WM, Yagupsky P, Welch DF, and Wilson DM. *Blood Cultures IV*. ASM Press: Washington, DC; 2005