

Frequently Asked Questions: Bloodstream Infection Event (Central Line- Associated Bloodstream Infection and Non-central line-associated Bloodstream Infection)

	Topic	Question	Response
1	Secondary BSI	<p>How do I determine if an LCBI is primary in nature or secondary to another site and therefore not reported as a CLABSI?</p>	<p>If you believe that there is a non-blood source of infection to which an LCBI may be secondary, you must first fully meet one of the NHSN site specific infection definitions (as defined in Chapter 17 [CDC/NHSN Surveillance Definitions for Specific Types of Infections], PNEU, UTI, SSI or VAE protocols). Once you have done this, apply guidelines located in Appendix 1, Secondary BSI Guide, found at the end of Chapter 4 (Bloodstream Infection Event [Central Line-Associated Bloodstream Infection and Non-central line-associated Bloodstream Infection]) in the NHSN manual. The blood culture must either be an element used to meet the site-specific criterion OR blood and site-specific specimen cultures (used to meet the infection criterion) must match for at least one organism. You may prefer to use the Secondary BSI flow diagrams found on page 4-26 and 4-27 of the BSI chapter.</p> <p>The rules for infection window period and secondary BSI attribution period must be followed as well. More guidance about these rules may be found in Chapter 2 (Identifying HAIs in NHSN). In the case of VAE, there must also be adherence to the guidance for assigning a secondary BSI to VAE, outlined in the VAE protocol.</p> <p>NOTE: If the patient does not meet any of the infection criteria in Chapter 17, PNEU, UTI, SSI or VAE then the LCBI must be reported as a primary LCBI and as a CLABSI if central line-association requirements are met.</p>

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2	Site-specific criteria and secondary BSI	How do I determine which site-specific criteria uses blood as an element in order to potentially meet secondary BSI criteria?	<p>In an effort to assist users, NHSN has developed the following tables for your convenience, which can be found in Chapter 4, Appendix 1:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3">Organisms cultured from blood as an element</th> <th colspan="3">Organisms cultured from blood <u>with</u> imaging test evidence of infection</th> </tr> <tr> <th>Site</th> <th>Element</th> <th>Page</th> <th>Site</th> <th>Element</th> <th>Page</th> </tr> </thead> <tbody> <tr> <td>BURN</td> <td>1</td> <td>17-20</td> <td>BONE</td> <td>3a</td> <td>17-4</td> </tr> <tr> <td>JNT</td> <td>3c</td> <td>17-4</td> <td>DISC</td> <td>3a</td> <td>17-4</td> </tr> <tr> <td>MEN</td> <td>2c & 3c</td> <td>17-7</td> <td>GIT</td> <td>2c</td> <td>17-16</td> </tr> <tr> <td>OREP</td> <td>3a</td> <td>17-19</td> <td>IAB</td> <td>3b</td> <td>17-17</td> </tr> <tr> <td>PNU2</td> <td>Lab finding</td> <td>6-6</td> <td>SA</td> <td>3a</td> <td>17-8</td> </tr> <tr> <td>PNU3</td> <td>Lab finding</td> <td>6-8</td> <td>USI</td> <td>3b & 4b</td> <td>17-22</td> </tr> <tr> <td>UMB</td> <td>1b</td> <td>17-22</td> <td>ENDO</td> <td>4a, 4b, 5a & 5b (specific organisms) 6e & 7e plus other criteria as listed</td> <td>17-9</td> </tr> </tbody> </table>	Organisms cultured from blood as an element			Organisms cultured from blood <u>with</u> imaging test evidence of infection			Site	Element	Page	Site	Element	Page	BURN	1	17-20	BONE	3a	17-4	JNT	3c	17-4	DISC	3a	17-4	MEN	2c & 3c	17-7	GIT	2c	17-16	OREP	3a	17-19	IAB	3b	17-17	PNU2	Lab finding	6-6	SA	3a	17-8	PNU3	Lab finding	6-8	USI	3b & 4b	17-22	UMB	1b	17-22	ENDO	4a, 4b, 5a & 5b (specific organisms) 6e & 7e plus other criteria as listed	17-9
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3	Secondary BSI to lower respiratory events in locations performing VAE surveillance	How do I identify a secondary BSI for lower respiratory tract events in ventilated patients in adult locations where VAE surveillance is performed?	<p>We understand this is an area of confusion. Please note, for purposes of NHSN, for a bloodstream infection to be determined to be secondary to a primary infection site, (i.e. related to an infection at another site, such that primary site of infection may have seeded the bloodstream secondarily) the patient must first meet one of the NHSN site specific definitions. For example, for a secondary bloodstream infection to be deemed secondary to PNEU, the PNU2 or PNU3 definition must be met first. You cannot call a bloodstream infection secondary to PNEU based on a clinical diagnosis of pneumonia or solely based on a matching pathogen recovered from a lower respiratory tract specimen and blood. To figure out whether a positive blood culture can be called a secondary bloodstream infection (BSI) related to a lower respiratory tract event, consider the following steps: 1) Does the patient meet any of the VAE definitions? a. If the PVAP definition is met, then you may attribute the blood culture to the VAE (as a secondary BSI) IF the blood culture meets the various requirements as outlined in the VAE protocol—the organism isolated from blood must match an organism isolated from the respiratory tract culture used in meeting the PVAP definition AND the blood culture must be collected during the 14-day VAE event period. b. If only the VAC or IVAC definition is met, then the positive blood culture CANNOT be secondary to the VAE because according to the VAE surveillance protocol, BSIs cannot be deemed secondary to VAC or to IVAC.2) If the PVAP definition is met, a positive blood culture can either be secondary to the VAE (if it meets the VAE secondary BSI criteria outlined in the protocol and summarized in 1a, above), or secondary to one of the other major HAI sites (e.g., if another Chapter 17 definition or PNEU, UTI or SSI definition is met), or it may be a primary BSI/CLABSI.3) If only the VAC or IVAC definition is met, or if no VAE definition is met, then the positive blood culture can be evaluated to see if it is secondary to any of the major sites as defined in Chapter 17 or PNEU, UTI or SSI event protocols. If the patient does not meet one of these other definitions, the BSI may need to be reported as a primary BSI/CLABSI.</p>

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	Topic	Question	Response
4	Secondary BSI and PNU1	Can I assign a secondary BSI to a PNU1?	<p>No. A secondary BSI cannot be attributed to PNU1. If a BSI is thought to be secondary to a pneumonia and the blood culture collection date did not occur within the infection window period such that it could be used as an element to meet the PNU2 definition, reassess to determine if the PNU2 definition can be met within the PNU1 RIT. See the example and table in the cell that follows. All elements necessary to satisfy the PNU1 definition occur within the infection window period. The date of event is 2/14. The PNU1 RIT is 2/14 through and including 2/27. Blood cultures collected on 2/20 are reported as positive for <i>Pseudomonas aeruginosa</i>. While this collection date is within the secondary BSI attribution period for PNU1, a secondary BSI cannot be reported for PNU1 as the blood culture is not used to satisfy the PNU1 definition and there is no site specific culture to which the blood culture pathogen can match. However, during the RIT, all elements needed to meet the PNU2 definition are present such that the PNU2 definition can be met using the blood culture as an element. The specific event reported is edited to represent PNU2 (PNU1 changed to PNU2). The date of event remains as 2/14, as does the originally determined RIT (2/14 through 2/27). The BSI can be attributed as secondary to PNEU. If the PNU2 definition had not been met as described above and additionally, another specific site infection for which the BSI could be attributed as a secondary was not found, the BSI would be reported as a primary BSI/CLABSI.</p> <p>Please see the example below.</p>

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Topic	Question	Response			
		Date	RIT	Infection Window Period	Secondary BSI Attrib. Period
		2/10			
		2/11			
		2/12			
		2/13			
		2/14		CXR: new infiltrate, new onset cough	
		15		CXR: infiltrate, T = 38.9°C, cough, worsening gas exchange	
		16			
		17			
		18			
		19			
		20		Blood Cx: Pseudomonas aeruginosa, CXR: infiltrate, WBC = \geq 12,000, increased respiratory secretions	
		21		CXR: infiltrate,	
		22			
		23			
		24			
		25			
		26			
		27			
		28			
		29			

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	Topic	Question	Response
5	MBI-LCBI vs. secondary BSI	<p>How do I determine if a positive blood culture otherwise meeting criteria for a Mucosal Barrier Injury-Laboratory Confirmed Bloodstream Infection (MBI-LCBI) should be reported as secondary to a gastrointestinal infection (GIT) when the patient has symptoms that may be due to their disease process <u>or</u> due to an infectious process (e.g., nausea, vomiting, diarrhea, etc.) ?</p>	<p>CLABSI surveillance is intended to capture BSIs that are associated with the central line itself. This association may be due to either suboptimal insertion or maintenance issues. In such an infection the blood is believed to be the primary site of infection. The purpose of the creation of the MBI-LCBI criteria was to enable NHSN to identify those BSIs that are believed to be the result of the patient’s weakened immune state and the accompanying alteration of the gut. In such a situation, the patient truly has a <u>primary BSI</u>, because there is not an <u>infection</u> at another site. The gut is simply the source of <u>colonizing</u> organisms which seed the bloodstream. Both of the above situations, where the BSI is primary in nature, are different from those in which the BSI is believed to be secondary to an <u>infection</u> at another site. An example is a BSI that is secondary to a GIT infection in which the bloodstream becomes a second site of infection through seeding from the original infection site. The goal of adding MBI-LCBI criteria to CLABSI surveillance is: 1. To capture as MBI-LCBI: BSIs that occur in the absence of other infections (i.e., primary BSI) but in the context of non-infectious disturbances (such as neutropenia or GVHD) 2. To avoid reporting as MBI-LCBIs those BSIs which are due to another site of infection (i.e. secondary BSI). This is not always an easy determination. It will take some clinical judgment, but the aim should be to capture as MBI-LCBIs those BSIs where the patient’s symptoms (nausea, vomiting, diarrhea, etc.) are felt to be due to the GVHD or treatment side effects and NOT due to an infectious process in the gut. The organisms involved may provide some suggestion in this determination. When clinical interpretation indicates that there is an infectious process occurring in the gut, AND the patient meets one of the GI infection criteria, AND the guidance in Appendix 1 Secondary BSI Guide is followed, then such BSIs should be considered secondary to another site of infection and not reported as CLABSI.</p>

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	Topic	Question	Response
6	MBI-LCBI Reporting	When will MBI-LCBI data be removed from the CLABSI data that is submitted to CMS?	<p>NHSN does not plan to remove the requirement for hospitals to include MBI-LCBIs as a part of in-plan CLABSI reporting. Facilities will still be required to report these events to NHSN if the location's monthly reporting plan includes CLABSI surveillance. Instead, NHSN will be removing the MBI-LCBI counts from the main LCBI tracking metrics and will create a separate report for MBI-LCBI tracking. This means that the MBI-LCBIs will not be included in any of the CLABSI metrics used for national reporting or for files that are shared with CMS. They will only be used in specific MBI-LCBI reports. CDC intends to use the 2015 NHSN data as the new baseline for all of the HAI SIRs calculated for subsequent years. Therefore, it is in the 2016 SIR data, which will use 2015 as the baseline, that users will see the MBI-LCBIs removed from their LCBI counts reported to CMS. We believe that the continued collection and tracking of MBI-LCBI data is important because these infections cause significant morbidity and mortality for patients and through their identification and measurement exists the potential to identify new prevention efforts.</p>

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	Topic	Question	Response
7	Distinguishing serial reportable infections from single, unresolved infection	<p>Does the Repeat Infection Timeframe, (RIT) eliminate the continuation of an infection investigation?</p> <p>If a person meets the definition for CLABSI with a positive <i>Staphylococcus aureus</i> culture on hospital day 12 and on hospital day 18 another blood culture is positive with an eligible pathogen, is this a new CLABSI?</p>	<p>Beginning in 2015, a Repeat Infection Timeframe (RIT) was established to remove subjectivity of distinguishing serial reportable infections from previous unresolved infections. The RIT supersedes previous guidance for a continuation of an infection provided in previous years. If an infection of the same type, (e.g. BSI) is identified outside of the RIT of a previously identified primary infection, a new event is identified and reported. In the example given, if a BSI with a date of event on hospital day 12 is identified, and another positive blood culture that meets LCBI criteria with a date of event within the 14 day RIT is identified, no new LCBI would be reported. The next possible date of event for a new BSI would be after the 14 day RIT has elapsed or hospital day 26 (15 days after the first identified BSI date of event)</p> <p>For complete details, please see Chapter 2 - http://www.cdc.gov/nhsn/PDFs/pscManual/2PSC_IdentifyingHAIs_NHSNcurrent.pdf</p>

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	Topic	Question	Response
8	Event Type	<p>A patient has a blood culture collected on hospital day 4 that meets LCBI criteria. No central line is in place and a BSI event is identified. On hospital day 5 a central line is inserted. Another blood culture is collected on hospital day 8, that is positive for a pathogen, and the patient meets CLABSI criteria. Do I change the primary event to a CLABSI?</p>	<p>Do not change the device-association determination during the RIT. If a primary BSI is identified that begins the RIT, do not "upgrade" the event if a patient later meets CLABSI criteria during the RIT of the BSI. The second positive culture is considered an extension of the first non-central-line associated BSI.</p>

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	Topic	Question	Response
9	Blood culture collection methods	If two blood cultures are drawn, one through a central line, and one from a venipuncture and the venipuncture culture is negative for growth but the line culture grows an NHSN pathogen, does this meet the CLABSI criteria?	<p>Yes. Blood cultures collected by any means, either through venipuncture or collected through existing vascular catheters must be considered in your surveillance of BSI. Therefore, a blood culture which is collected through a vascular catheter and that is positive for an organism, is considered a positive blood culture for CLABSI surveillance.</p> <p>The collection site (venipuncture site or line drawn) of the blood culture does not impact the determination of central line association for a BSI. A BSI is determined to be central line associated if on the date of event a central line was in place for >2 calendar days, with day of device placement being Day 1, AND a central line was in place on the date of event or the day before.</p>
10	Defining "separate occasions"	What does the term "on separate occasions" mean in relation to blood cultures positive for common commensals?	<p>The term "on separate occasions" is included among the requirements for laboratory-confirmed bloodstream infections when only common commensals are cultured from the blood (LCBI 2). Poor blood culture technique can result in contamination of blood specimens and the growth of common commensals on culture. The requirement for at least 2 blood cultures with matching common commensals to be collected during separate occasions was developed in order to avoid mis-identifying contamination due to poor blood culture technique as a true bacteremia. Blood cultures drawn from different sites or at different times should undergo separate decontamination (skin prep). Both of these are examples of "separate occasions". In each example, if both cultures sets are positive, the chances are less that contamination was the cause than if the 2 positive blood culture sets were collected from only a single blood collection (e.g., collected using a vacutainer and attaching multiple bottles after a single decontamination). IF a person were to perform skin preparation, and then perform a single accession (either skin puncture OR accessing the same line or port) and collect multiple bottles, those would be considered a single accession (or occurrence). Think about "occasions" as referring to the act of disinfection of the access site. The intention is to ensure that the blood cultures are collected following different site disinfections.</p>

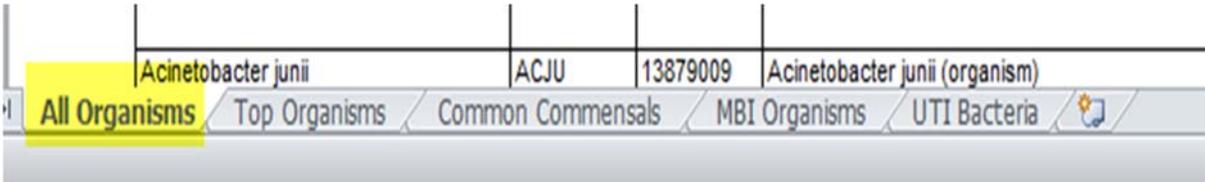
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	Topic	Question	Response
11	Common Commensals Are Single Element	If blood culture with matching common commensals are the first element of the LCBI 2 criterion to be met, and they are drawn on consecutive days, which date should be used for the date of event?	The paired common commensal blood cultures are considered a single element of LCBI 2. If signs/symptoms occur within the Infection Window Period prior to the first collected blood culture, record the date the first element (symptom) used to meet LCBI 2 occurred. If the signs/symptoms occur AFTER the blood cultures, use the date of the first positive blood culture collection during the infection window period as the date of event.

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	Topic	Question	Response
12	Matching Common Commensals	<p>I recently encountered a patient who had <i>S. capitis</i> in one culture and <i>S. auricularis</i> in another (on consecutive days). I know that if neither one of the cultures had not been speciated and left as coagulase-negative staphylococcus, then I could consider them as companion cultures. However, because they speciated both cultures would I be correct to call this a contamination?</p>	<p>Since both coagulase-negative staphylococci were speciated and were found to be of different species, they are not considered as companion (i.e., matching) cultures and, therefore, do not meet LCBI 2 criteria.</p>

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	Topic	Question	Response
13	List of Common Commensals	Where can I find the list of NHSN Common Commensals?	<p>The NHSN Organism List (Excel document) is located on the CLABSI page - http://www.cdc.gov/nhsn/acute-care-hospital/clabsi/index.html, under Supporting Materials. There is a tab titled Common Commensal at the bottom of the spreadsheet.</p> <p>When an organism is not found on the NHSN Common Commensal list, but is found on the NHSN All Organism list, it is considered a pathogen. When viewing the NHSN Organisms List, be sure to select the correct tab at the bottom of the spreadsheet.</p> 
14	Updated common commensal list	Some organisms that used to be included on the common commensal list have been taxonomically re-categorized and are no longer included on the list. Why?	<p>NHSN has made a decision to only expand the common commensal organism list with organisms from the original list which have maintained their original genus identification and have only had new species identification. This means that as organisms are identified to belong to a genus not originally on the list, they will be excluded from the common commensal list.</p>

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	Topic	Question	Response
15	MBI-LCBI-organisms list	How was the list of organisms included in the Mucosal Barrier Injury-Laboratory Confirmed Bloodstream Infection (MBI-LCBI) criteria, developed?	The list of organisms included in the MBI-LCBI was developed by consensus of the HICPAC surveillance working group, made up of infectious disease professionals, healthcare epidemiologist, infection preventionists, and state public health representatives. The list of organisms included in the definition is intended to represent those that are most likely to be attributed to mucosal barrier injury. We recognize that not all mucosal barrier injury related bloodstream infections will be categorized as MBI-LCBI. CDC staff will be evaluating the list of MBI-LCBI organisms on an ongoing basis to determine if changes are needed.
16	Pre-existing central lines	When patients are admitted to an inpatient unit with a pre-existing central line in place, which is not accessed during the hospitalization, are those days included in the central line-day count?	No. Pre-existing central lines should be included in the central line-day count beginning on the first day that they are accessed and continuing until the patient is discharged or the line is discontinued, whichever comes first. Therefore, if a patient is admitted with a central line which is not accessed until hospital day 4, the line should <u>not</u> be included in the central-line day counts until day 4 and then included every day until the patient is discharged or the line is discontinued. If the line is never accessed, it is never counted in the central line day counts. “Access” is defined as line placement, infusion or withdrawal through the line. NOTE: if a patient has another central line in place at the same time, which is being accessed, central line days will be counted for the patient.

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	Topic	Question	Response
17	Removal and reinsertion of a central line	How do I count calendar days when a central line is removed and later reinserted?	If a central line is present for any part of a calendar day, then that day contributes to the minimum day's requirement for the CLABSI. If a full calendar day passes without a central line being present, then the day count begins again for CL days, once the CL is reinserted.
18	Midline catheter	Does a midline catheter qualify as a central line?	Midline catheters by description are not intended to end in one of the great vessels. However, the location of the tip of the catheter is the determining factor and a recent chest x-ray report may indicate the true location. Also, consider the line's use. To qualify as a central line, it must be used for infusion, withdrawal of blood, or hemodynamic monitoring.
19	Catheter tips	Are central line catheter tips used to meet the NHSN LCBI criteria? Why or why not?	No. Catheter tip cultures are not used for NHSN CLABSI surveillance for several reasons. Catheter tip cultures have been shown to have higher rates of contamination than blood cultures. Furthermore, not all laboratories are able to perform quantified catheter tip cultures. Catheter tips are a part of other types of non-NHSN surveillance such as catheter-related BSI (CRBSI) which is generally thought of as a clinical definition, used when diagnosing and treating patients. The Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011 address CRBSI and may be helpful when addressing a physician's questions: http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf
20	Multiple central lines	If a patient has two central lines in at the same time, how do I determine to which line to attribute the positive blood culture?	You will not be required to attribute a CLABSI to a specific central line. Instead you will simply be required to answer whether or not a central line was in place greater than 2 calendar days on the date of the BSI event and also in place on the day of the event or the day before the event.

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	Topic	Question	Response
21	Purulent drainage from IV site	If a patient has purulent drainage from an old IV site, but a negative blood culture how do I report this to NHSN?	Consult the criteria for VASC-Arterial or Venous Infection available at http://www.cdc.gov/nhsn/PDFs/pscManual/17pscNosInfDef_current.pdf . Such a patient would meet criterion 4. If your facility is monitoring for these types of infection, enter this into NHSN as a VASC event.
22	Intraaortic balloon pumps (IABP)	Are intraaortic balloon pumps (IABP) considered central lines?	No. Because IABPs are not generally used for infusion, blood withdrawal or for hemodynamic monitoring, they are not considered central lines.
23	Femoral arterial lines	Are femoral <u>arterial</u> lines considered central lines in NHSN?	No. Because the femoral artery is not among the list of great vessels defined for CLABSI surveillance in NHSN, a catheter in this vessel is not considered a central line. Do not include femoral artery catheter days in your count of central line days.

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24	Dialysis patients	<p>If in-patients provided dialysis by dialysis staff members, either in the patient's room or in the dialysis unit, develop a CLABSI, to which location is the CLABSI attributed? Our unit nursing staff does not access the dialysis catheter and sometimes this is the patient's only central line.</p>	<p>In both circumstances, the CLABSI must be attributed to the inpatient location where the patient is housed overnight. In this scenario the dialysis unit does not have overnight patients. Therefore, there can be neither patient day counts nor central line counts for that location and there is no way within NHSN to perform CLABSI surveillance in that location. NOTE: A new optional field was added to the BSI form in 2014: Any hemodialysis catheter present? Yes No. This may be used to identify issues that are believed to be related to dialysis care. Remember, the CLABSI will still need to be reported to NHSN for the unit in which the patient is housed.</p>

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	Topic	Question	Response
25	Chronic dialysis patients	When performing central line-associated bloodstream infection (CLABSI) surveillance in an inpatient dialysis location, should chronic dialysis inpatients be included?	Yes. If CLABSI surveillance in an inpatient dialysis location is part of your monthly reporting plan, all patients in that location must be included in CLABSI surveillance. (NOTE: inpatient dialysis locations that are not bedded locations, i.e., patients do not spend the night in these locations, but instead are transported there for dialysis and return to another bedded location for the remainder of their care, cannot participate in the NHSN CLABSI protocol at this time). See question and answer directly above.
26	Contracted staff	How should CLABSIs be reported when they develop in patients whose only central line is accessed solely by <u>contracted</u> dialysis staff?	Facilities are responsible for all of the care which is provided in their facilities. This includes care provided by employed staff and contracted staff alike. Therefore such a CLABSI would be reported for the facility in which the patient is housed.

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	Topic	Question	Response
27	Patient reported fever	Can I use patient reported fever to meet CDC/NHSN LCBI criterion 2 for present on admission (POA)?	Patient reported signs and symptoms can be used as an element to meet CDC/NHSN site-specific criteria. When fever is a symptom, the patient must report an objective finding (e.g., temperature of 100.8 F), and subjective statements are excluded (e.g., "I felt feverish" is not acceptable). Documentation of signs/symptoms from a transferring facility is also acceptable. For example, a patient is transferred from a nursing home and is afebrile upon admission to the hospital. The nursing home documentation indicates that the patient had a fever the morning of admission. If the nursing home documented or reported fever is included as part of the patient's admission/facility record, then it can be used as one of the elements to meet CDC/NHSN LCBI criterion 2.
28	Patient manipulation of central line	If an inpatient is suspected of accessing their own vascular catheter e.g., injecting illicit drugs, and a BSI develops, is this BSI attributed to the facility?	Yes, if the patient meets the definition of a BSI this is attributable to your facility. A facility must protect the line as best they can. Prevention efforts may include providing a patient sitter and/or removal of the catheter as soon as is clinically possible.
29	Hypotension	What is the definition of hypotension when evaluating common commensal for CLABSI?	NHSN does not provide a specific value for this vital sign. Instead, each facility should use the vital sign parameters as stated in its policies and procedures for clinical documentation.

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30	Reporting Locations	<p>In addition to ongoing ICU surveillance, what locations are now required to be included in reporting CLABSI for participation in CMS quality reporting programs?</p>	<p>Information on locations that are included in reporting was outlined in the September 2014 NHSN newsletter, which was sent to all NHSN users. The September newsletter can found here http://www.cdc.gov/nhsn/PDFs/Newsletters/vol9-3-eNL-Sept-2014.pdf and the specific information you are seeking is on page 13.</p>