CLAB Surveillance of System Standardisation Checklist

The definition for CLAB used is the CDC NHSN as identified in: http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf

The definition for 'secondary infection source' used is: http://www.cdc.gov/ncidod/dhqp/pdf/nnis/NosInfDefinitions.pdf

The definition for a potential contaminant used is: http://www.asid.net.au/hicsigwiki/index.php?title=NHSN_potential_contaminant_organisms

Important Features	Rationale	JAN	FEB	MARCH	APRIL		
Objective process for evaluation performed by an identified panel which includes doctor responsible and staff not directly involved in clinical care of the patient	Ensure all clinical information is used and gives opportunity for all avenues to be explored	✓	✓	✓	✓		
System to ensure majority of blood cultures collected are 2 sets from different sites	Best practice. Avoids interpretation difficulties. If two sets are not taken then CLAB definition will never be meet for some organisms			✓	✓		
Surveillance of positive blood cultures	Be confident that all positive blood cultures are reviewed, that includes ones recorded up to 48 hours post discharge form ICU CVL infection usually won't become manifest for > 48 hr post insertion and since the typical length of stay in ICU is only 2-4 days, many cases will be detected after leaving the ICU.	✓	✓	✓	✓		
Source from infection at another site is ruled out using CDC/NHSN criteria.	If BSI is being attributed to another site – that infection needs to meet the CDC definition for that, it is not enough to say there was possibility of another source	✓	✓	✓	✓		
Final decision whether CLAB is present is made by objective personnel not directly involved in clinical care of the patient.	Important to assure impartiality is maintained	✓	✓	✓	✓		
Clear approach for investigating new fever/sepsis in your patients.	Need to be confident that blood cultures are being taken when required to be able to capture all possible CLAB			✓	✓		
Hour of admission and discharge are captured.	Enables decision where to attribute CLABSI.	✓	✓	✓	✓		
CVL status of all patients who have been admitted is recorded. Date, time and location of insertion and removal.	1. Denominator data to enable calculation of CLAB per CVL days. 2. BSI occurring up to 48 hr after removal of a line are included as potential CLABSI [CDC CLABSI 2012 p4-1].			✓	✓		
All positive blood cultures up to 48 hr after discharge are captured.	BSI recorded up to 48 hr after leaving the unit are attributed to the ICU [CDC CLABSI 2011 transfer rule p 4-2] CVL infection usually won't become manifest for > 48 hr post insertion and since the typical						

	length of stay in ICU is only 2-4 days, many cases will be detected after leaving the ICU.						
BSI organism is classified as pathogen or potential contaminant according to the standard list.	Organisms not on the list should be discussed among other DHBs to establish consensus for future reference. [some examples are given in CDC CLABSI 2011 p4-4]	✓	✓	✓	✓		
Strain identity of possible pathogens is interpreted according to standard criterion.	[CDC CLABSI 2012 note 4&5 p4-5]	✓	✓	✓	✓		
Decision whether CLABSI or not is made by a panel including the doctor responsible and others not in the treating team or the person who inserted the CVL.	Gives some impartiality while making use of clinical information.	✓	✓	✓	✓		
All positive and negative blood cultures and cultures from other body sites are available to the team deciding whether it is CLABSI or not.	Enables detection of all potential CLABSI and assessment as to whether it is contamination or infection at another site.	✓	✓	✓	✓		
Quality Improvement Activity							
Feedback process for identifying blood culture collection practices	Allows for identification of blood culture collection issues			✓	✓		
Feedback process for identifying number of possible CLABs that did not meet definition	Allows for problem resolution of issues preventing correct identification of CLAB	✓	✓	✓	✓		
Quality Assurance Activity							
Sample scenarios are run through the local protocol to assure consistent interpretation							
A sample of cases are reviewed by another DHB team to check agreement with interpretation.							
A sample of positive and negative cases are audited to confirm accuracy and completeness of data collection.							

Completed for Christchurch ICU 9/5/12 by Ruth Barratt CNS IP&C
Comments: The ICU has developed guidelines for taking blood cultures which only came into effect in march/ April. Therefore I cannot comment on what happened prior to that except that in general there would have been more blood cultures taken than less so it is highly unlikely that we would have missed a possible CLAB due to no cultures taken.