2011

Electronic surveillance for healthcare-associated central line-associated bloodstream infections outside the intensive care unit

Keith F. Woeltje
Washington University School of Medicine in St. Louis

Kathleen M. McMullen
Barnes-Jewish Hospital

Anne M. Butler
University of North Carolina at Chapel Hill

Ashleigh J. Goris
Progress West Health Center

Joshua A. Doherty
BJC HealthCare

Follow this and additional works at: https://digitalcommons.wustl.edu/open_access_pubs

Part of the Medicine and Health Sciences Commons

Recommended Citation
Woeltje, Keith F.; McMullen, Kathleen M.; Butler, Anne M.; Goris, Ashleigh J.; and Doherty, Joshua A., "Electronic surveillance for healthcare-associated central line-associated bloodstream infections outside the intensive care unit." Infection Control and Hospital Epidemiology, 1086-1090. (2011).
https://digitalcommons.wustl.edu/open_access_pubs/789

This Open Access Publication is brought to you for free and open access by Digital Commons@Becker. It has been accepted for inclusion in Open Access Publications by an authorized administrator of Digital Commons@Becker. For more information, please contact engeszer@wustl.edu.
Electronic Surveillance for Healthcare-Associated Central Line–Associated Bloodstream Infections Outside the Intensive Care Unit
Author(s): Keith F. Woeltje, Kathleen M. McMullen, Anne M. Butler, Ashleigh J. Goris, Joshua A. Doherty
Reviewed work(s):
Source: Infection Control and Hospital Epidemiology, Vol. 32, No. 11 (November 2011), pp. 1086-1090
Published by: The University of Chicago Press on behalf of The Society for Healthcare Epidemiology of America
Stable URL: http://www.jstor.org/stable/10.1086/662181
Accessed: 03/03/2012 17:25

Your use of the JSTOR archive indicates your acceptance of the Terms & Conditions of Use, available at http://www.jstor.org/page/info/about/policies/terms.jsp

JSTOR is a not-for-profit service that helps scholars, researchers, and students discover, use, and build upon a wide range of content in a trusted digital archive. We use information technology and tools to increase productivity and facilitate new forms of scholarship. For more information about JSTOR, please contact support@jstor.org.
Electronic Surveillance for Healthcare-Associated Central Line–Associated Bloodstream Infections Outside the Intensive Care Unit

Keith F. Woeltje, MD, PhD; Kathleen M. McMullen, MPH, CIC; Anne M. Butler, MS; Ashleigh J. Goris, RN, MPH, CIC; Joshua A. Doherty, BS

BACKGROUND. Manual surveillance for central line–associated bloodstream infections (CLABSIs) by infection prevention practitioners is time-consuming and often limited to intensive care units (ICUs). An automated surveillance system using existing databases with patient-level variables and microbiology data was investigated.

METHODS. Patients with a positive blood culture in 4 non-ICU wards at Barnes-Jewish Hospital between July 1, 2005, and December 31, 2006, were evaluated. CLABSI determination for these patients was made via 2 sources: a manual chart review and an automated review from electronically available data. Agreement between these 2 sources was used to develop the best-fit electronic algorithm that used a set of rules to identify a CLABSI. Sensitivity, specificity, predictive values, and Pearson’s correlation were calculated for the various rule sets, using manual chart review as the reference standard.

RESULTS. During the study period, 391 positive blood cultures from 331 patients were evaluated. Eighty-five (22%) of these were confirmed to be CLABSI by manual chart review. The best-fit model included presence of a catheter, blood culture positive for known pathogen or blood culture with a common skin contaminant confirmed by a second positive culture and the presence of fever, and no positive cultures with the same organism from another sterile site. The best-performing rule set had an overall sensitivity of 95.2%, specificity of 97.5%, positive predictive value of 90%, and negative predictive value of 99.2% compared with intensive manual surveillance.

CONCLUSIONS. Although CLABSIs were slightly overpredicted by electronic surveillance compared with manual chart review, the method offers the possibility of performing acceptably good surveillance in areas where resources do not allow for traditional manual surveillance.
2 general surgical wards were chosen for surveillance. These units were selected to provide a variety of patient types, and the anticipated patient volumes were within our ability to conduct manual surveillance (routine surveillance by hospital infection prevention was not in place in these units). All patients on the surveillance wards with a positive blood culture between July 1, 2005, and December 31, 2006, were included in the study. Human studies committee approval for the project was obtained before initiation.

**Manual Surveillance**

Patients who had a positive blood culture were identified from the hospitalinformatics database. The charts of these patients were reviewed using a standardized data collection tool, and data were entered into an SPSS data set. The data were reviewed with a hospital epidemiologist to confirm a CLABSI using the NHSN definitions current at the time. After the initial data abstraction, NHSN criteria for CLABSI changed—specifically, patients with a single culture positive for a common skin contaminant who received antimicrobial therapy no longer met the definition for a CLABSI.9 Our manually collected data set had sufficient information to allow reclassification of patients who no longer met the revised NHSN definition.

**Electronic Surveillance**

Patients on the surveillance wards with positive blood cultures were identified from the hospitalinformatics database. Non-organism concepts (eg, Aspergillus galactomannan) that were reported to the database as “positive cultures” were filtered from the data set before analysis. Additional electronically available data (eg, positive cultures from other sites, laboratory values, patient temperature, and presence of a central line) were pulled by standardized query into an analysis data set. A series of yes/no electronic rules applicable to the determination of CLABSI were applied (similar to rules reported by Trick et al9). These rules were then applied in different combinations to determine which set of rules most closely matched the CLABSI determination from the manual surveillance. The individual rules are as follows:

1. Hospital acquired: positive blood culture was obtained 48 hours or more after hospital admission.
2. Non–common skin contaminant:
   a. Culture positive for non–common skin contaminant pathogen or culture positive for common skin contaminant9 that was confirmed with another positive culture of the same organism within 3 days.
   b. Culture positive for non–common skin contaminant pathogen or culture positive for common skin contaminant9 that was confirmed with another positive culture of the same organism within 3 days and the patient had a fever (temperature more than 38.0°C within 48 hours of the blood culture).
3. Central venous catheter: patient had a central venous catheter in place at the time of culture or discontinued within 48 hours before culture.
4. No secondary bloodstream infection: no positive culture of the same organism from any other body site (many combinations were evaluated, and a selected few are shown below).
   a. Anytime during the admission.
   b. Anytime during the admission before the blood culture date.
   c. Anytime during the admission before or within 7 days after the blood culture date.
   d. Anytime during the admission within 14 days before or 7 days after the blood culture date.

Any other positive blood culture within 7 days of the CLABSI culture was assumed to be part of the same infection and so was not counted as a new infection. Any positive
culture with the same organism as the CLABSI culture within 14 days of the initial culture was also assumed to be part of the same CLABSI.

Sensitivity, specificity, predictive values, and Pearson’s correlation were calculated for the various new rule sets, using manual chart review as the reference standard. For the best-fit model, $\chi^2$ analysis was completed comparing the manual and electronic CLABSI rates.

**Results**

During the study period, 391 positive blood cultures from 331 patients were evaluated. Eighty-five (22%) of these were confirmed to be CLABSI by manual chart review. Individual rules, not unexpectedly, performed relatively poorly. The best-fit model, which included rules 1, 2b, 3, and 4b, predicted 90 CLABSIs (23%; Table 1). The CLABSI rate by manual surveillance was 6.37 cases per 1,000 central line–days (95% confidence interval, 5.0–7.7) versus 6.75 cases per 1,000 central line–days (95% confidence interval, 5.4–8.1; $P = .76$).

CLABSIs remain slightly overpredicted compared with manual chart review. Preliminary analyses of the original data set (before the change in NHSN criteria; data not shown) evaluated specific sites (eg, wounds and urine) alone and in a variety of combinations, but they did not result in improvement over using all culture sites to eliminate potential secondary bloodstream infections; these analyses were not repeated with the updated data set. Likewise, analyses of the initial data set evaluating the utility of incorporating the patient’s white blood cell count did not yield improved performance and so were not repeated in this set of analyses.

In addition to overall performance, the performance of the best-fit model on a month-to-month basis for each ward was determined (Figure 1). While electronic surveillance tended to predict higher CLABSI rates than manual surveillance, overall the trend lines were comparable. In ward 1, the number of cases from manual surveillance was 26, whereas electronic surveillance found 33; in ward 2, 13 and 12 cases were found, respectively; in ward 3, 26 and 27 cases were found, respectively; and in ward 4, 20 and 18 cases were found, respectively ($P > .5$ for the comparison of manual to electronic CLABSI rates for each individual ward).

**Discussion**

A variety of studies have proposed electronic methods of surveillance for bloodstream infections in general. However, most institutions have focused on CLABSIs, because these seem more amenable to prevention interventions. The study by Trick et al provided a solid step toward performing automated surveillance for CLABSI, but those investigators did not have access to central line data electronically. Our
current study shows results comparable to, if not slightly better than, those of Trick and colleagues and has the advantage that surveillance could be done completely electronically. One potential weakness of our current study is that after developing the rules we did not validate them on a separate set of patients. As noted below, we are in the process of implementing these rules in multiple hospitals, which will allow for additional validation.

Our electronic surveillance has overall higher rates than manual surveillance. At least some of the infections that were identified electronically were likely secondary infections that did not have a site culture that met our electronic criteria (data not shown). Conversely, we may be eliminating true CLABSI if the same organism from another site does not represent a true secondary infection (eg, *Candida* in a sputum sample). While this may argue for including some element of human review, there may be advantages to a completely objective surveillance method. A steady body of literature has indicated the existence of significant interrater variation in determining the presence of healthcare-associated infections.15-17 There is no evidence to suggest that interrater reliability improves with years of experience, and even within institutions there appears to be significant interobserver variations in determining whether a patient has a CLABSI.18 This variability, combined with less comprehensive case finding, tends to lead toward underreporting of CLABSI by traditional surveillance.6,19-21 Thus, while electronic surveillance may report a higher rate than traditional surveillance, the “true rate” is probably somewhere in between. Since we did not have traditional manual surveillance in place in the study units, we were not able to validate this assumption as part of our study. However, a pilot validation study comparing our algorithm with traditional surveillance rates in our ICUs did find that the “validated rates” were between the electronic rates and the rates reported by infection control (data not shown).

Fully automated electronic surveillance for CLABSI outside the ICU offers the potential for performing whole-house CLABSI surveillance without requiring a dramatic increase in resources. This extended scope may help hospitals comply with regulatory requirements for performing surveillance for CLABSI, such as the Joint Commission’s National Patient Safety Goals. Because this method uses different definitions than traditional surveillance, healthcare personnel should not try to compare the electronic rates with NHSN rates. In particular, electronic surveillance rates will include unconfirmed secondary bloodstream infections, and “zero” rates cannot be expected. Nevertheless, we believe that electronic surveillance can provide valuable insight into areas of the hospital with better or worse CLABSI performance to help us target our improvement interventions. The electronic surveillance will also show the impact of such interventions. To assist in the acceptance of fully automated surveillance in non-ICU areas, we have decided to use a term other than “CLABSI rates” so as not to confuse them with NHSN-type rates. We are using the term “NICER,” for non-ICU CLABSI electronic rates. Currently, we are in the process of implementing NICER surveillance at all BJC HealthCare facilities.

**ACKNOWLEDGMENTS**

We thank Vicky Ferris, RN, CIC, for her assistance in classifying bloodstream infections and Nhial T. Tutlam, MPH, for data collection.

**Financial support.** This work was supported by grant 00426-30805-01 from the Barnes-Jewish Hospital Foundation. K.F.W. has received support from the Centers for Disease Control and Prevention’s Prevention Epicenter Program (grant UR8/CCU715087).

**Potential conflicts of interest.** All authors report no conflicts of interest relevant to this article.

Address correspondence to Keith F. Woeltje, MD, PhD, Division of Infectious Diseases, Washington University School of Medicine, 660 South Euclid Avenue, Campus Box 8051, St. Louis, MO 63110 (kwoeltje@dom.wustl.edu).

**REFERENCES**


