Appendix Table 3: Concerns with CLABSI Surveillance in Home Infusion Therapy

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|  | Infusion Nurses (N=87) | Healthcare Epidemiologists (N=27) | Home Infusion Agencies (N=26) |
| Lack of standardized definition or benchmarking | 8 (9.2%) | 5 (18.5%) | 2 (7.7%) |
| Underreporting and inconsistent reporting | 14 (16.0%) | 14 (51.9%) | 1 (3.8%) |
| Over-reporting | 2 (2.3%) | N/A | N/A |
| Difficulty with data access and data tracking | 7 (8.0%) | 12 (44.4%) | 7 (26.9%) |
| No system for surveillance | (4.6%) | 5 (18.5%) | N/A |
| Attribution of infection | 5 (5.7%) | 1 (3.7%) | 2 (7.7%) |
| Unsanitary state of patients’ homes | 2 (2.3%) | N/A | 1 (3.8%) |
| Inability to get denominator data | N/A | 3 (11.1%) | 1 (3.8%) |
| Identifying root cause of CLABSI | N/A | N/A | 2 (7.7%) |
| Ensuring cultures are drawn appropriately | N/A | N/A | 1 (3.8%) |
| Poor communication | N/A | 3 (11.1%) | N/A |
| Staff education | 7 (8.0%) | 4 (14.8%) | N/A |
| Early recognition of CLABSI by nurses | 4 (4.6%) | N/A | N/A |
| Patient performing self-care may not report CLABSIs | 4 (4.6%) | N/A | N/A |
| Poorly trained or non-compliant patients or families | 4 (4.6%) | 1 (3.7%) | 2 (7.7%) |
| Inconsistency in care | 2 (2.3%) | N/A | 2 (7.7%) |
| Occlusions | 1 (1.1%) | 1 (3.7%) | N/A |
| No accountability, incentives, funding, or chain of command | N/A | 2 (7.4%) | N/A |
| CLABSIs occur infrequently | 3 (3.4%) | N/A | N/A |

Abbreviations: CLABSI: Central line associated bloodstream infection