Appendix Table 2: Methods for Tracking Complications in Central Line-Associated Bloodstream Infection in Home Infusion Therapy

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| --- | --- | --- | --- | --- |
|  | Infusion Nurses (N=87) | Healthcare Epidemiologists\* (N=27) | Home Infusion Agencies (N=26) | p-value |
| How does home infusion know to investigate a CLABSI?^ Message from patient or caregiver | 6 (6.9%) | N/A | 13 (26.0%) | <0.001 |
| Message from inpatient team | 6 (6.9%) | N/A | 12 (46.2%) | <0.001 |
| Home infusion laboratory result | 4 (4.6%) | 1 (3.7%) | 9 (34.6%) | <0.001 |
| Inpatient laboratory result | 4 (4.6%) | 3 (11.1%) | 8 (30.8%) | <0.001 |
| Message from discharge coordinator | N/A | N/A | 10 (38.5%) | N/A |
| Message from hospital infection prevention | 4 (4.6%) | 1 (3.7%) | 5 (19.2%) | 0.029 |
| Active chart surveillance or audits | 3 (3.4%) | 3 (11.1%) | 9 (34.5%) | <0.001 |
| Message from home health nurse | 10 (11.5%) | N/A | N/A | N/A |
| Active investigation once learn of hospitalization | 16 (18.4%) | 2 (7.4%) | N/A | 0.17 |
| Home health staff report tool | 6 (6.9%) | N/A | N/A | N/A |
| Patient symptoms | 5 (5.7%) | 6 (22.2%) | N/A | 0.011 |
| Complications tracked: Venous thromboembolism | 1 (1.1%) | 4 (14.8%) | 11 (42.3%) | <0.001 |
| Adverse drug event | N/A | 6 (22.2%) | N/A | N/A |
| Emergency department use | 1 (1.1%) | N/A | 11 (42.3%) | <0.001 |
| Unplanned hospitalizations or readmissions | 47 (58.0%) | 4 (14.8%) | 15 (57.7%) | <0.001 |
| Dislodgement, migration, malposition | 43 (53.1%) | 4 (14.8%) | 12 (46.2%) | 0.006 |
| Bloodstream infection | 47 (58.0%) | 9 (33.3%) | 15 (57.7%) | 0.19 |
| CLABSI | 55 (67.9%) | 10 (37.0%) | 19 (73.1%) | 0.026 |
| Occlusion | 45 (55.6%) | 3 (11.1%) | 14 (53.8%) | <0.001 |
| Phlebitis, extravasation, infiltration | 47 (54.0%) | N/A | 10 (38.5%) | 0.16 |
| Exit site infection | N/A | N/A | 9 (34.6%) | N/A |
| Damage or breakage | N/A | N/A | 10 (38.5%) | N/A |
| Person tracking complication: registered nurse | 53 (60.9%) | 8 (29.6%) | 10 (38.5%) | 0.007 |
| Licensed practical nurse | 2 (2.3%) | 0 (0.0%) | 1 (3.8%) | 0.88 |
| Epidemiologist | 11 (12.6%) | 2 (7.4%) | 2 (7.7%) | 0.64 |
| Infection preventionist | 16 (18.4%) | 4 (14.8%) | 2 (7.7%) | 0.42 |
| Pharmacist | 20 (23.0%) | 4 (14.8%) | 11 (42.3%) | 0.054 |
| Physician | 6 (6.9%) | 0 (0.0%) | 2 (7.7%) | 0.80 |
| Nurse practitioner or physician’s assistant | 2 (2.3%) | 0 (0.0%) | 0 (0.0%) | 0.88 |
| Administrator | 12 (13.8%) | 2 (7.4%) | 2 (7.7%) | 0.53 |
| Data entry staff | 6 (7.0%) | N/A | 3 (11.5%) | 0.55 |
| Pharmacy technician | 1 (1.1%) | N/A | N/A | N/A |

Abbreviations: CLABSI: central line-associated bloodstream infection; N/A: not applicable

\*Healthcare epidemiologists were asked specifically about their main hospital’s internal home infusion agency.

^Other responses: 1 infusion nurse reported taking action after learning about an office visit. 1 infusion nurse reported investigating when they learned about a venous catheter being removed or a patient being initiated on antibiotics. 1 healthcare epidemiologist reported not knowing how this information was obtained.