## Central Line Associated Blood Stream Infection Validation Check List - Adults

Patient Identification Details:

Organism identified (*organism name*)

Date of first positive blood culture: [Click here to enter a date.]

Date of Central Line insertion: [Click here to enter a date.]

Type of Central line: (circle) CL  PICC

*Instructions: To meet the case definition, events must fulfil either criteria 1 or 2 AND the date criteria.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria 1** | | | |
|  | **Please tick** | | **Initials** |
| Does the patient have a recognised pathogen in one or more blood cultures? | Y | N |  |
| Is it likely the blood stream infection is a CLABSI and not related to an infection at another site? | Y | N |  |

**OR**

**If any of these are NO, this DOES NOT fit the criteria for a CLABSI**

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria 2:** | | | |
| **If a common skin contaminant is identified, please complete below** | **Please tick** | | **Initials** |
| Was the same common skin contaminant cultured from two or more sets of blood cultures drawn on separate occasions within 48 hours of each other\*? | Y | N |  |
| Is there at least one of the following signs or symptoms:  fever (>38°C) or chills or hypotension within 24 hours of collection of the positive culture? | Y | N |  |
| Is it likely that the signs, symptoms or positive laboratory results are related to a CLABSI and not infection at another site? | Y | N |  |

**AND**

**If any of these are NO, this DOES NOT fit the criteria for a CLABSI**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date criteria** | | | |
| **Date of BSI and Catheter insertion** | **Please tick** | | **Initials** |
| Was the date of the BSI at least 48 hours after the CI/PICC was inserted? | Y | N |  |
| If the CI/PICC was removed, was the BSI within 24 hours of the line removal? | Y | N |  |

**If any of these are NO, this DOES NOT fit the criteria for a CLABSI**

Does this CLABSI meet surveillance criteria Y  N

Is this attributable to your facility Y  N

(If no, please ensure you contact the relevant facility to ensure this is reported)

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Person completing this form)

Date Completed. [Click here to enter a date.]

**Please keep this document as evidence that you have validated this indicator.**