Central Line Associated Bloodstream Infections (CLABSI), Prevention Strategies and the Impact of a CLABSI Prevention Unit Champion

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Goal

Prevent CLABSI by raising awareness of CLABSI prevention strategies.

Introduction

- 250,000 CLABSI occur a year with 30,000 associated deaths.
- CLABSI are associated with prolonged hospital stay, increased medical costs, and they have a negative impact on hospital reimbursement.
- Establishing a culture of safety, on-going education and using best practice evidence are all initiatives to eliminate CLABSI.

Background

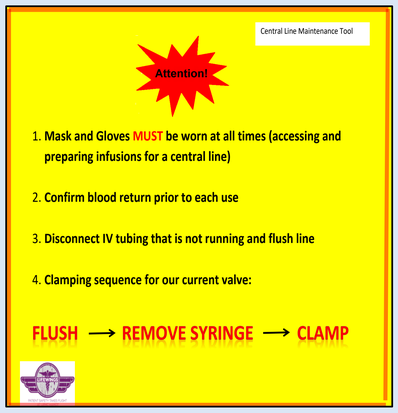
- Informal and formal survey and surveillance on CLABSI events from 2011-2018 identified trends and omission of critical steps that can lead to CLABSI events.
- Decreased CLABSI occurred with education and when a barrier or product was used to avoid cross-contamination.
- Increased CLABSI are associated with lines used for lab draws, lipids, and improper flushing.
- Hardwire safety tools for central line insertion and maintenance were developed and implemented house wide on November 3, 2015.
- Recruiting and formation of the CLABSI Prevention Unit Champions (Champs) began January 2016.

Method

Timeline graph correlating CLABSI events with interventions.

Tools and Interventions

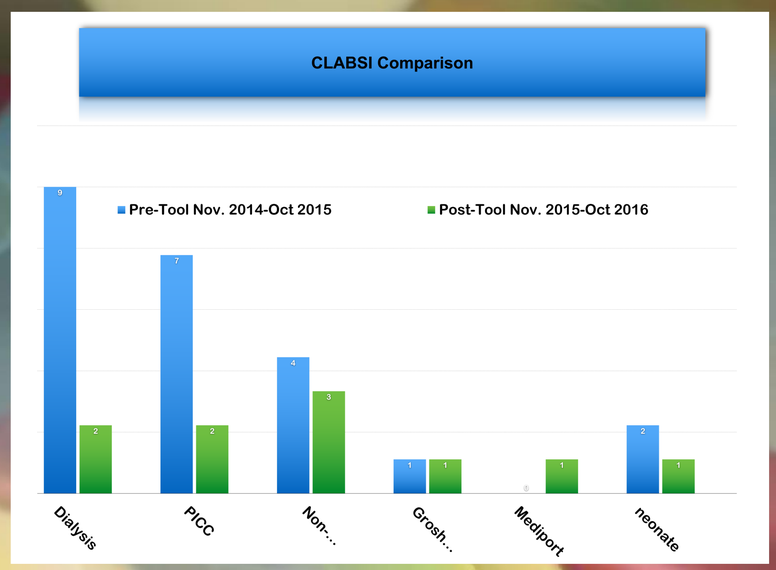
- Hardwire Safety Tools (HWST) for central line insertion placed on central line carts, including a STOP sign during insertion and central line maintenance tool posted on iv poles.

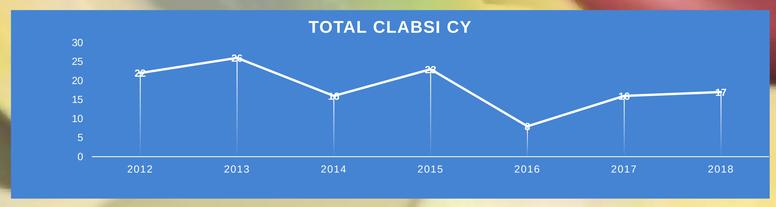


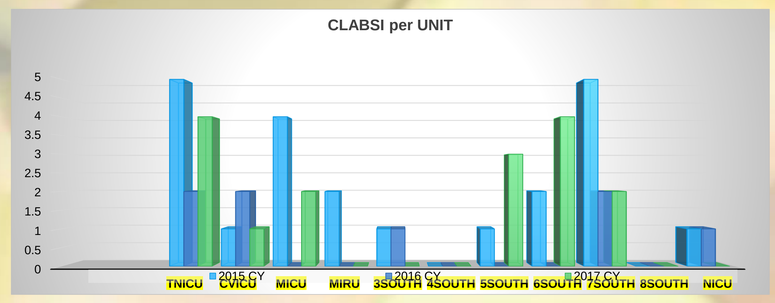
- Nursing Residency follow up at six months for hands on central line education.
- Key Take Away Badge-key central line points.
- "Ask 10": Champs ask 10 co-workers the CLABSI question of the month to identify areas to target education.
- Champ Quarterly Rounding: hands on simulation with rationale and survey and surveillance.
- Champ Critical Analysis Form to identify modifiable risk factors and interventions.
- Daily Line Necessity Form for rounding.
- Hands on simulation models for Mandatory Madness.
- Poster on each unit with key points and monthly CLABSI rates updated by Champs.

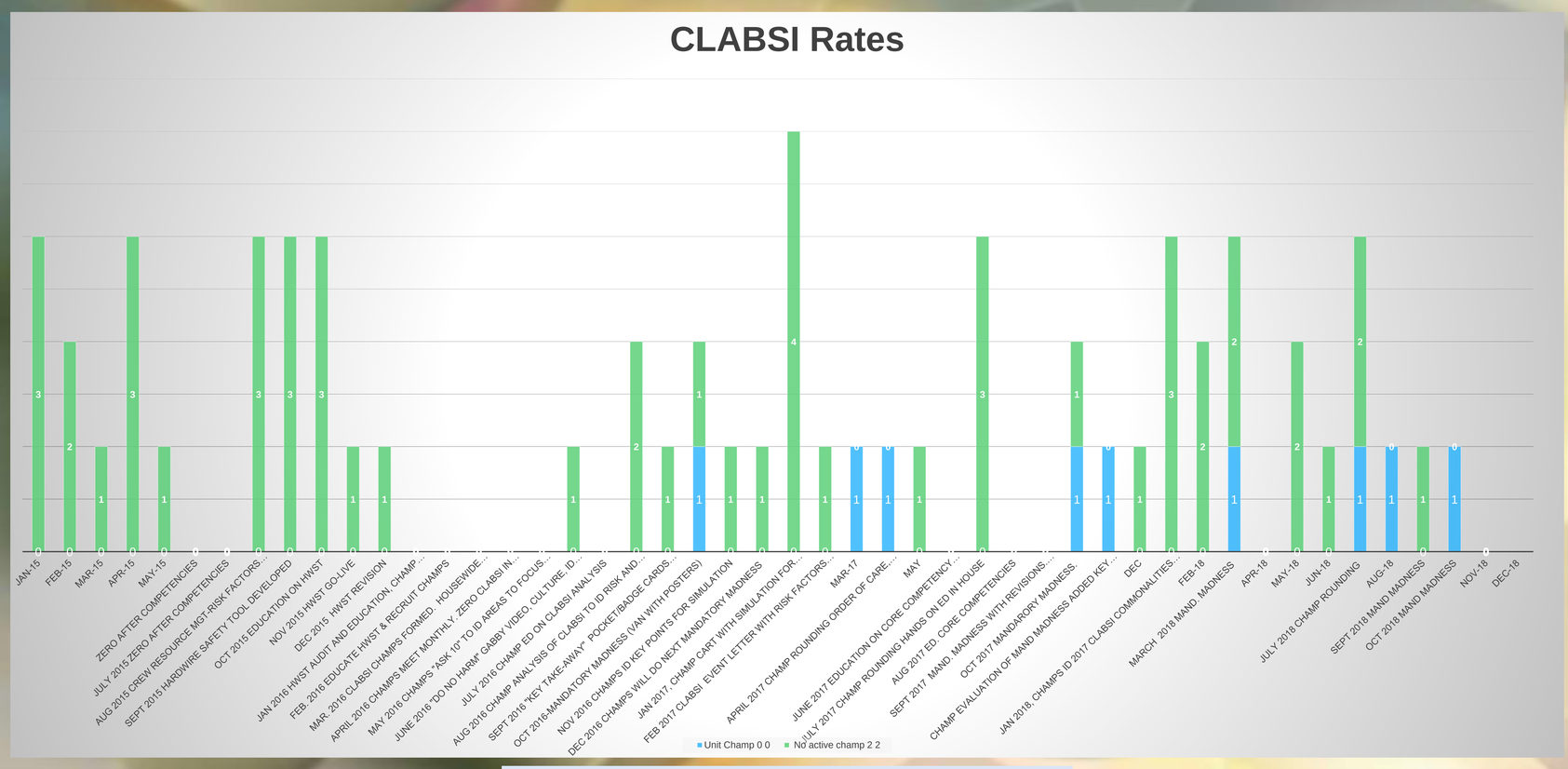
Results

- 22 CLABSIs twelve months prior to the HWST with ongoing unit education.
- 6 CLABSI after implementation.
- 167 days with zero CLABSI house wide, an additional 4 months with zero CLABSI with an active Champ.
- The top 3 modifiable risk factors identified by the Champs include: cross contamination of insertion site and hub, improper flushing increased with lines used for labs, blood, and lipids, and units that did not have and active unit Champ.









Acknowledgement

Thank you to the CLABSI Prevention Unit Champions.

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