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Asking Before Accessing

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Asking BEFORE Accessing

Plan for CLABSI reduction

CHI Health Lakeside

Jen Baumert MSN, RN-BC, OCN

Carly Hornig MSN, RN
• Spring 2016: FY16 revealed 7 CLABSI’s on the Med-Surg/Oncology unit
  – What was wrong? Where is the problem?
    ▪ CLABSI Taskforce initiated
    ▪ Research compiled
    ▪ Point Prevalence Studies completed with multiple vendors to look for areas of opportunity
      • Maintenance: where education was needed
    ▪ Scripting changed with patients
      • CHG ‘Treatment’ vs CHG ‘Bath’
      • RN vs CNA to provide CHG treatment
      • Education offered by staff/physicians- RN and HMS partnership
      • Tailored education related to Infection Risk
Time Frame:

- Education- algorithm and mandatory skills day
- Mandatory Inpatient RN skills day
- Increased midline trained RNs/vein viewer
- Daily collaboration with IP, Clinical coordinators/educators and staff
- 2 RN skin checks to include central line dressings
- Education/communication provided to Radiology and ER (ensure same message)
- Audits changed from 2x weekly, to every shift
- Phone ‘buddies’
- Partnership with Lab to have peripheral draws to be the standard
• Created a CLABSI taskforce comprised of engaged bedside/administrative staff with a variety of viewpoints
  – Med-Surg/Oncology Director
  – Clinical Practice Coordinator
  – Operations Performance Improvement Committee Oncology Representative (Quality)
  – Infection Prevention
  – Shared Governance/Partnership Council Nurse Representative
  – Day Shift/Night Shift RN
  – ED Educator
• What did the research say?
  – Limited options

  – Limited Viewpoints

  – Central Line Maintenance

  – Cleanliness/ No discussion about limiting access
• Central line dressing maintenance and compliance was reviewed during a separate point prevalence study
• Quality of dressings was reviewed by an independent product vendor
• Educational opportunities were revealed
  • Inconsistencies with dating dressings
  • ‘Reinforcing’ rather then redressing
  • Securement
  • Disinfection Caps
  • CHG
  • Clean, Dry and Intact
Where is the problem?

- Drill downs of previous CLABSI’s indicated insertion/access was not the immediate concern

- Staff partnered with various vendors to perform point prevalence studies to aid in determining opportunities for improvement

- Every single central line was reviewed for ‘cap’ placement
  - Inconsistencies between the units, PICCs and other Central lines
  - Inconsistencies with all ‘access points’
CHG treatments

• CHG treatments are given to any patient prior to surgery and with a central line
• Scripting with patients evolved from ‘CHG baths’ into ‘CHG treatments’ to reinforce the importance of completion
• Education is given to patients about the importance of CHG treatments. RN’s have taken on this responsibility (CNA’s previously did this) to reinforce the ‘treatment’ scripting. Once hardwired, education was completed with CNA’s at skills day and the process was re-introduced
• If a patient refuses even after education, the MD is notified. We have partnered with Hospital Medicine Service (HMS) who have agreed to discuss the importance of CHG in their rounding

Staff developed an algorithm to help guide best practice in determining circumstances to access central lines.
Mandatory Skills Day Checklist

- All inpatient nurses were required to attend a mandatory annual skills day
  - 4 different times over a course of two different days were offered to staff to attend
  - Stations were offered for a variety of topics including central line maintenance and Foley care
Skills Day

- The central line care station was taught by experienced Oncology staff nurses trained as ‘super users’
- Staff were educated on:
  - Proper central line technique
  - Educational checklists
  - RN’s required to perform a return demonstration
  - Instructed on the new policy and procedure regarding central lines
Patient Education: A snapshot

- Patient education developed to assist patients to understand CLABSI's

- Education created by an Oncology Clinical Practice Coordinator

- This information was reviewed with patient by either Oncology RN or Oncology Clinical Practice Coordinator

About 41,000 blood stream infections occur in hospital patients with central lines each year. These infections can be life threatening and increase the length of hospital stays.

How we prevent central line infections:
- Using a central line only when there is no other way to give a medication.
- Washing our hands and/or using alcohol-based hand rub frequently.
- Wearing a mask and sterile gloves when changing the dressing.
- Performing a daily chlorhexidine gluconate (CHG) treatment.
- Carefully handling medication and fluids given through the central line.
- Adding a sterilizing cap to any IV lines that are not in use.
- Assessing the central line frequently for signs of infection.
- Checking daily to see if the central line is still needed.

What can you do?
- Wash your hands with soap and water or use alcohol-based hand rub before and after you eat or use the bathroom.
- Ask your visitors to wash their hands when they enter and exit your room.
- Do not allow visitors to touch your central line or IV tubing.
- If you do not see your healthcare providers clean their hands, remind them to do so.
- If your central line bandage comes off or becomes wet or dirty, tell your nurse immediately.
- If the skin around your central line becomes sore or red, tell your nurse immediately.

Reference: Centers for Disease Control and Prevention http://www.cdc.gov/HAI/
• Increased number of mid-lined trained nurses as an alternative option for ‘hard stick’ patients
• Purchased two ‘Vein Viewers’ to assist staff with IV starts
  – Increase confidence
  – Increase options
Do we need this?

• Questioning daily lines:
  – Is the reason for the line still relevant?
    ▪ If not, can it be removed?
  – What is that reason?
  – Prior to inserting a central line-
    ▪ Is this the best course of action?
  – No access = no infection
  – Collaboration with physicians

Audits: Take 1

- This original audit was done by day shift RN’s 3x a week.
- Audit sheets were handed out at morning huddles by the nursing supervisors.
- Assigned RN’s responsibility to complete and turn in the audit.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line Description</td>
<td>________________</td>
</tr>
<tr>
<td>Line Access/Insertion Date</td>
<td>________________</td>
</tr>
<tr>
<td>Was line present on admission</td>
<td>Yes or No</td>
</tr>
<tr>
<td>Dressing Change Date</td>
<td>________________</td>
</tr>
<tr>
<td>Reason changed</td>
<td>________________</td>
</tr>
<tr>
<td>If port last needle change</td>
<td>________________</td>
</tr>
<tr>
<td>Dressing documented intact per policy daily</td>
<td>Yes or No</td>
</tr>
<tr>
<td>Dressing Intact, including Biopatch (visual)</td>
<td>Yes or No</td>
</tr>
<tr>
<td>Curocaps on all access points (lumens/tubing) (visual)</td>
<td>Yes or No</td>
</tr>
<tr>
<td>Line Flushed and Blood Return Noted (Documentation)</td>
<td>Yes or No</td>
</tr>
<tr>
<td>CHG Bath Documented Daily</td>
<td>Day 1 __________ Day 2 ______ Day 3 _______</td>
</tr>
<tr>
<td>If No, was the refusal documented daily</td>
<td>Yes or No</td>
</tr>
<tr>
<td>If No, was re-education documented daily</td>
<td>Yes or No</td>
</tr>
<tr>
<td>Daily CL Indication Documented</td>
<td>Yes or No</td>
</tr>
<tr>
<td>Central Line Education handout Documented</td>
<td>Yes or No</td>
</tr>
<tr>
<td>Staff Feedback/Follow Up</td>
<td>________________________________________________________________________</td>
</tr>
<tr>
<td>Stop &amp; Resolve Actions by Auditor</td>
<td>________________________________________________________________________</td>
</tr>
</tbody>
</table>
Revised audit was implemented by the CLABSI taskforce
• More robust and detailed
• Staff RN completed a review on the previous shift
  • Increased conversations and awareness by auditing peers
• Audit was completed twice a day (once a shift)
  • Data collected and reviewed by CLABSI taskforce
• Started in summer of 2016 - obtained 2 full quarters of data
• Final audit version was developed and distributed to staff approximately 9 months from origination of the CLASBI taskforce
• CLASBI taskforce noted when reviewing charting, inconsistencies noted between charts and audits
• Audit simplified to look for ‘biggest bang for the buck’.
• Audits completed and visualized by day shift RN supervisors
Auto calculates compliance
Phone buddies..........

• Implemented ‘Phone Buddies’ system
  – Automatic reaction is to answer ringing phone
  – Handoff to ‘Buddy RN’ when changing Central Line dressings
  – ‘Buddy’ is a RN on same nursing station
    ▪ Same person to coordinate lunch with
  – Minimal break in patient care
Barriers to Success

• Buy in from staff
  – Seeing the need for so many audits
  – Another thing to do
• Mandatory skills day/education
  – Anything mandatory can be unpopular
• Would we see results?
  – Unsure of success
• Wait and see
  – No immediate gratification
• Follow up words with actions
  – If I don’t do it what happens?
Lakeside House wide: By the numbers

• Lakeside went approx. 630 days house wide without a CLABSI
• All inpatient units meeting NDNQI quality metric for CLABSI in at least 5/8 quarters
• Daily uniformed audits performed on all units
• FY18 Mandatory inpatient RN skills days completed (3rd year in a row)
• 100% administrative support
• ‘Good Catches’ shared with staff- education re: Ports/line days
• Centers for Disease Control and Prevention http://www.cdc.gov/HAI/


• Lopez, A.C. (2011) A quality improvement program combining maximal barrier precaution compliance monitoring and daily chlorhexidine gluconate baths resulting in decreased central line bloodstream infections. *Dimensions of Critical Care Nursing*, 30, 293-298


Thank You