
Abstract:

Our BMTU experienced an increase in CLABSI in March -June 2010. This occurred in spite of the BMTU having implemented all recommended CLABSI prevention practices. It was determined that their CLABSI infections were a mixture of early (4 CLABSI <14 days suggesting insertion-related) and late (8 CLABSI >14 days suggesting maintenance-related) infections. Since the early CLABSI, were essentially all associated with PICC (peripherally inserted central catheter) lines, we developed a collaboration with our Interventional Radiology group. It was discovered that the central line checklist was not being done by a second person. In addition, inserter specific CLABSI rates were generated and fed back to Interventional Radiology. For the late CLABSI the BMTU Nurse Manager, Infection Preventionist, and Hospital Epidemiologist began twice weekly rounds on all BMT unit patients to evaluate compliance with central line maintenance practices to assess: central line dressings being clean, dry, and intact; bloody dressings changed within <24 hours, date of dressing change noted; dressings changed within 7 days for transparent dressing or 2 days for gauze dressing; routine and correct use of Biopatch; IV tubing changed in 96 hrs and any IV tubing not infusing properly capped with sterile end cap. Deficiencies were pointed out and corrected real time. Nursing staff were re-educated. After full implementation, staff nurses
became involved in the rounding process.