
Abstract:

Central Line Associated Bloodstream Infections (CLABSI) continue to result in mortality, morbidity and increased healthcare costs. Retrospective analysis of CLABSI rates since 2008 in our Critical Care Unit (CCU) demonstrated marked variability despite practice changes and continued staff education. Unit nurses demonstrated an awareness of the CLABSI bundle components but felt CLABSI was â€œunavoidableâ€ based on patient acuity. A culture change which fostered accountability and reduced CLABSI was imperative.