HIGHLAND HOSPITAL

An Affiliate of the

UNIVERSITY of ROCHESTER MEDICAL CENTER

Every Line Every Day - CLABSI Reduction Outside of the Intensive Care Setting

Sharon Nersinger, RN, MS

Janet I Taylor, SCM, RN and Jessamine Scipione, BSN, RN, CCRN

Purpose:

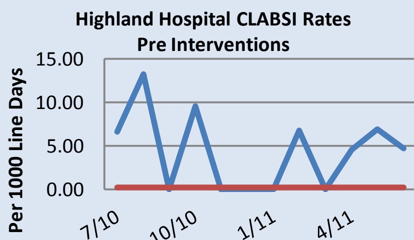
In line with the ANA/AONE Principles for Collaborative Relationships between Clinical Nurses and Nurse Managers and national initiatives to reduce harm to hospitalized patients, an interdisciplinary team was tasked with reducing the CLABSI rate on a non-ICU pilot unit from baseline to zero.

Objectives:

1. Identify common clinical practice failures that lead to an increased potential for patient harm & use that knowledge to develop CLABSI reduction strategies
2. Apply cultural & team work strategies to clinical practice to reduce the potential of CLABSI infection.

Significance:

CLABSI's have an attributable morbidity rate of between 4% & 20% making elimination an organizational patient safety priority. Analysis of the differences between ICU and non-ICU units found that non-ICUs did not have the same culture of accountability for central line maintenance and monitoring.



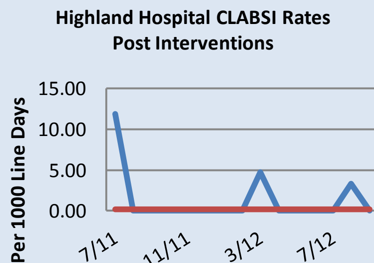
Strategy for Implementation:

The non-ICU unit with the highest line utilization and infection rates was selected to implement a pilot program as a small test of change.

Steps in Implementation:

The program consisted of several areas of focus:

1. Standardization of processes based on evidence based practice.
2. Identification of failures and clinical practice variations through intensive daily auditing of each central line by the Unit Manager, Safety Nurse Coordinator or Unit Safety Nurse.
3. Immediate feedback on deviation utilizing a mentoring non-punitive approach with positive feedback given for care that met standard as well.



Evaluation:

Unit efforts resulted in 8 months with zero CLABSIs versus 5 in the prior 2 months. Common practice variations identified included failure to assess & document every shift, late dressing changes, loss of dressing integrity, failure to label lines & lack of compliance with lumen flushing policy.

Implications for Practice:

Lessons learned support the establishment of learning environments and cultures. Direct involvement of the Nurse Manager increased staff knowledge and accountability while concurrent feedback motivated staff to take ownership of clinical practice and CLABSI rates while fostering team building.