Einstein - CLABSI Prevention Success Story

Issue: CLABSI rates remain higher than national and state benchmarks in our 500+ bed urban teaching hospital, 70% of central-line usage occurs outside the ICU. Despite our ability to greatly reduce CLABSI by focusing on standardizing policy and procedures for insertion and care and maintenance of CVC, rates on medical/surgical units remain increased. Our mean CLABSI rate in 2011 for our 6 medical/surgical units is 1.4/1000 CVC device days compared to NHSN pooled mean rate of 1/1000 CVC device days and the state mean rate of 0.67/1000 CVC device days.

Process: The CLABSI Prevention Team (CPT), in collaboration with the Nursing, Infection Prevention and Control and Quality Management Departments, is driven by the front-line staff nurses, “unit champions” from each inpatient unit. The goal of CPT is to eradicate CLABSI by empowering the unit champion to implement strategies to reduce CLABSI by identifying the knowledge and practice deficits related to the care and maintenance of CVC. The unit champions perform weekly care and maintenance observations. On a day selected by the unit champion the nurse assesses all CVC on the unit reviewing: the integrity of the dressing; CVC dressing is changed according to policy; IV administration tubing is changed according to policy. Based on the observations the unit champion focuses on the particular deficits on their unit and develop and implement the appropriate interventions. This forces the staff nurse to identify unit barriers and improve the practices they can control. Unit champions then develop in-services correcting knowledge deficits; provide opportunities for return demonstrations on the CVC dressing and IV tubing changing procedures; re-evaluate assuring proper practices are maintained.

Results: Decreased CLABSI rates in medical/surgical inpatient units from 1.4/1000 CVC devices days (2011) to current rate 0.86/1000 CVC device days (2012). Collectively all 6 medical/surgical units have sustained change and have had zero CLABSI for 9 months. The staff nurses now focus on the care and maintenance of CVC and days between infections rather than number of monthly infections.

Lessons Learned: Unit champions gained an increased awareness of unit ownership and accountability. Peer-to-peer interactions created trust, respect and an effective vehicle to share practice techniques. Unit ownership and team building are keys to problem solving & changing outcomes. The nurses learned that increased compliance of proper care and maintenance of CVC will result in a sustained decrease in CLABSI. Moreover, implementing actions based on staff nurses’ findings decreased CLABSI.