

# Challenges of CLAB prevention outside the ICU

## Learning Session Two

# CMDHB spread of CLAB initiative

- EC Feb 2010
- Theatres July
- NBC August
- Renal October
- Surgical 8 November
- NNU April 2011
- Surgical 9 May
- Surgical 34 June
- Radiology February 2012

# General challenges

- **Structural** – Much larger staff numbers than ICU. Changes to process/materials dependant on site. e.g. Renal required a different drape for their pack, Neonatal often only had 1 lumen lines therefore checklist had to be changed for TPN
- **Attitudinal** – each new unit had to engage staff and convince especially medical staff of value of CLAB prevention
- **Organisational** – each area had to work out a system for collecting CLAB checklists and inputting the data into the database, training requirements

# Developed a checklist for rollout

## CLAB – Prevention: Rollout to clinical areas

Item #	Issue	Progress	Date Implemented	Comment
1)	Identification of clinical leaders to support introduction			
2)	Key personnel consulted e.g. Service Manger, CND, Clinical Head			
3)	Proceduralists informed and in agreement with the insertion bundle			
4)	Observers of procedure informed, educated around and in agreement re monitoring of compliance with insertion bundle checklist.			
5)	Equipment in place e.g.			
a)	Availability of CVC catheter pack (includes PPE except gloves)			
b)	CHG 2% with 70% alcohol for insertion skin prep			
c)	Process to ensure additional equipment items are attachment to CVL pack. To include the insertion checklist.			
6)	Education plan in place 2 weeks prior to introduction			
7)	Person and process for collection/collation of CVL checklist identified.			
8)	Person to enter data identified and CLAB data base training organised with Terry Rings (Infection Prevention and Control)			
9)	Review of process for collection of blood cultures – ensure blood cultures X2 from different sites are taken routinely			
10)	Process for reporting of surveillance and checklist result process identified			
11)	Process to review CLAB identified that is timely and process for identifying risks and response identified			

# Surgical wards

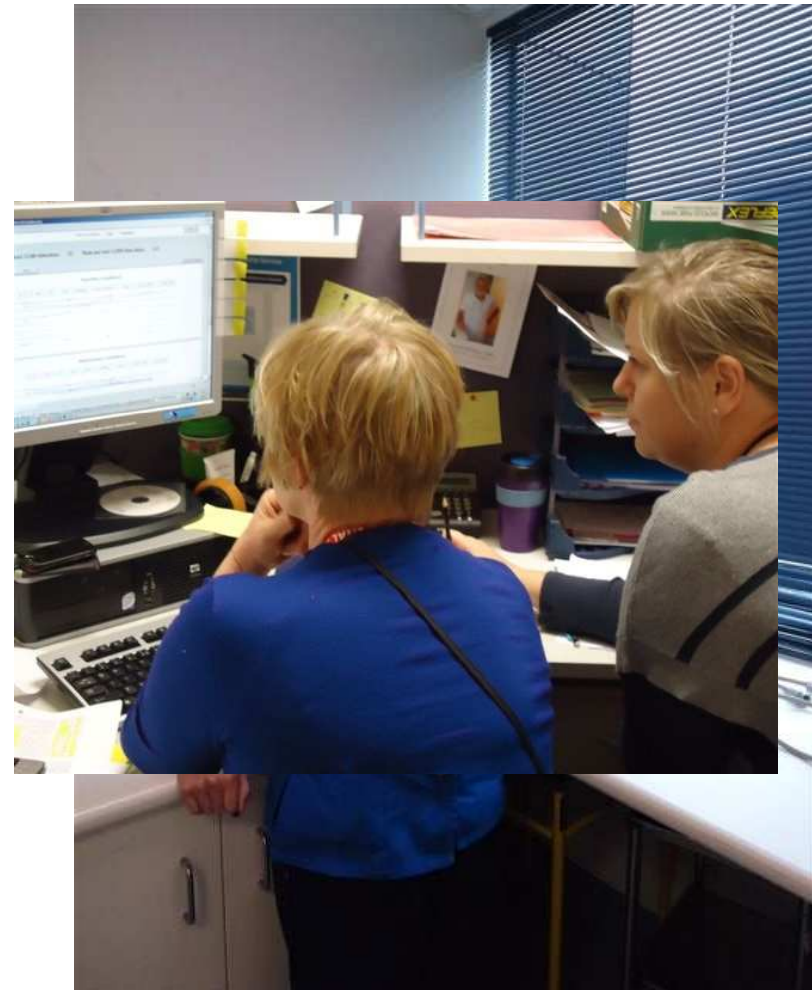
- Lead by Charge Nurse of one ward after a number of CLAB – came to us
- High users of central lines (especially PICC lines)
- High use of TPN



# Surgical wards

Lessons to date:

- Really important to have charge nurse on board and useful to have CN entering CLAB data at least initially
- Have more than 1 CLAB prevention champion to cover for absences
- Good central support

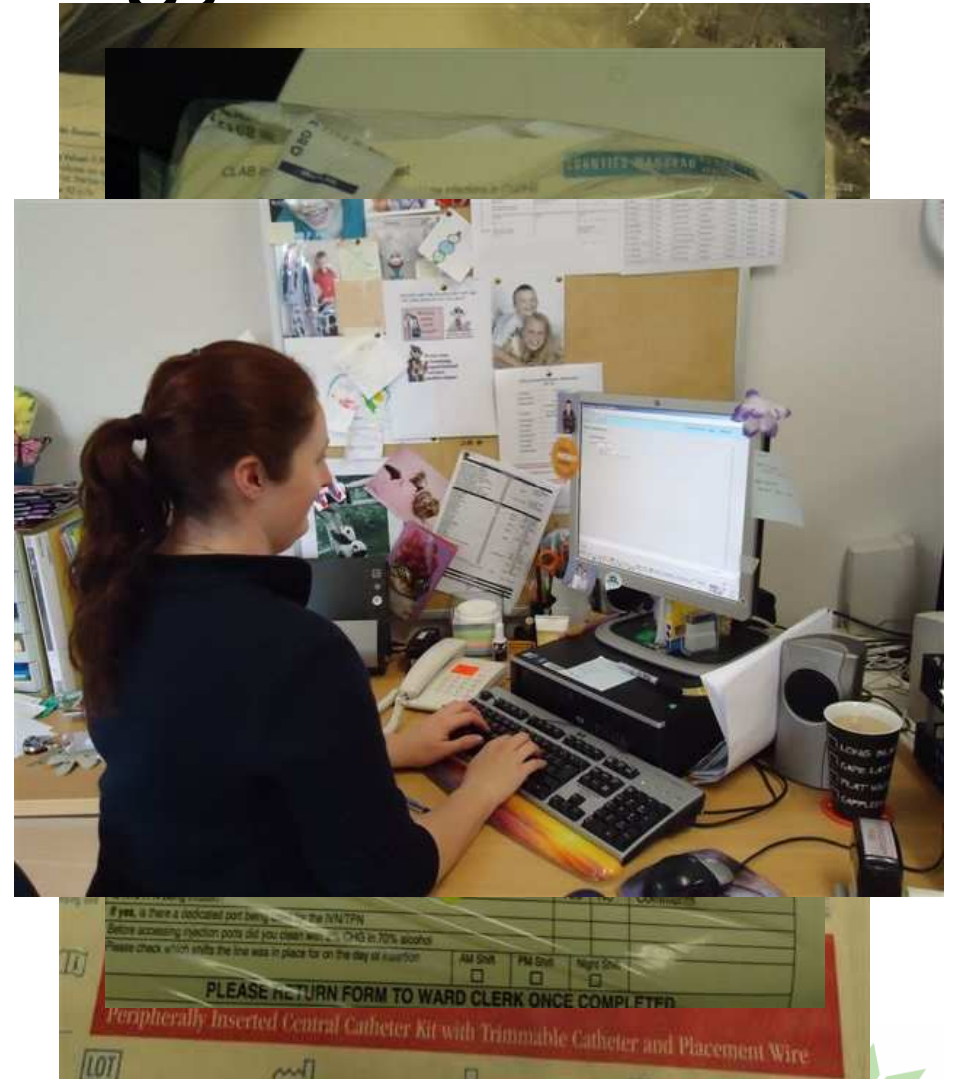




Propax, Disposable Blue

# Radiology

- Most difficult in our organisation
- Did not see need to change, large variation in practice
- Eventually decided to do it, but started without going through our rollout checklist
- Using own pack
- But are entering data reliably and insertion compliance is high





# What has been useful

- Insertion pack – became a ‘marketing device’ – tangible. Made the right thing to do the easiest thing to do.
- Rollout checklist
- Purpose-built database – easy to input data, easy for units to get their own reports

# CLAB database - [CLABINSERTIONentry]

Exit | About

**CLAB Bundle**

Back

NHI	Family Name	Given Name	DoB	Gender	PiMS
PRP1660	POWER	Cold R	08-Dec-1982	Female	demographics

Where was Line Inserted

Service:  Other:

Insertion Site

Side:  Left  Right

Cath Type:

Other:

Line coating:

Time:  Date Removed:

Time (24 hour clock)

Complete

Non compliant

Next, day 0 insertion

Hat

Mask

Sterile gown

Sterile Gloves

Full drape

Sterile Technique

High Risk Patients

Biopatch applied

Save Cancel

# Maintaining momentum

- Weekly meetings – quick up-dates, trouble shooting
- Database training – no more than 2 clicks to get a report
- Close relationship with IPC – Produced report template for investigating any CLAB
- Working with teams to post ‘days since last CLAB’ and weekly checklist compliance