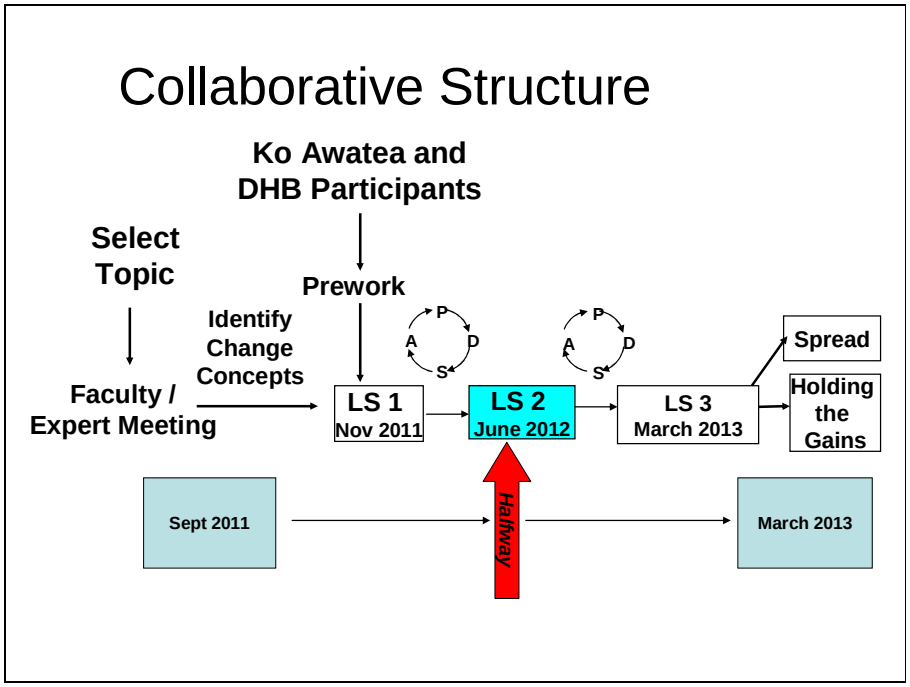
National Collaborative to Prevent Central Line Associated Bacteraemia
Summary and feedback on Learning Session 2

Introduction

The programme has now been running for 9 months and the progress and commitment from the DHBs to succeed in achieving zero CLAB through the implementation of the insertion and maintenance bundles for central lines has been very encouraging.

Wairarapa, Whanganui and South Canterbury have recorded zero lines to date but remain involved in the programme at a Regional Level and have indicated that there have benefits to them, particularly in learning more about the IHI Model for Improvement.

The second Learning Session was held in Wellington on the 18th and 19th June. This document summarises some of the key learning's and feedback from the participating teams.



Engagement

There was representation of 18 DHBs, Wairarapa and South Canterbury did not send any representatives but continue to be involved in the programme at a regional level.

The overwhelming feedback from the two days was that people felt reenergised and motivated to continue with the work and benefited enormously from the presentations, interaction with colleagues and planning for the next action period. The level of will, ideas and execution by the participating teams was impressive.

Highlights

There were a number of highlights some of which are recorded below. There may be others that have not been included and it would be great to hear from participants on these.

1. IHI Faculty member, Improvement Advisor and Consultant Brandon Bennett was able to spend the two days with us and was very well received by all the participants. His presentation on implementation highlighted the necessary steps that need to be taken to move from "testing" ideas to implementation. Following these key steps help enormously in sustaining the changes. The measures section highlighted the usefulness of standardising the graphics and portraying national and local unit data on one graphic as well as a graphic of New Zealand as a system. The third session, planning for the next action period focused on what each of he teams would be on their return to their units.

What one idea did you hear this week that you are not currently doing that you would like to test in your local environment?

1. Whanganui DHB Weekly team meeting and CNC to monitor maintenance bundles daily
2. Lakes DHB Getting Naked! And blood culture refinement
3. West Coast DHB Engagement of the charge nurses to monitor compliance with the maintenance bundles
4. Nelson Marlborough DHB Find an ally in Theatre to champion CLAB Zero
5. Hutt Valley DHB Plan to set up Weekly Team Meeting
6. Northland DHB Patient onus, Don't touch me with out hand washing! And blood culture review, including this in the checklist.
7. Taranaki DHB Weekly Team Meetings with a checklist
8. Tairawhiti DHB Feedback to staff to facilitate engagement on a info board, and increase awareness of infection control eg. Get Naked!
9. Midcentral DHB Audit of what sites our blood cultures are taken from
10. Southern DHB Engagement of the charge nurses to monitor compliance with the maintenance bundles
11. Waitemata DHB Ensure standardisation of blood culture collection, need to id ward champions for wards joining this work, improve identification of non-compliant lines
12. Bay of Plenty DHB High risk patient awareness, Chlorex dressing, advertising and awareness, and change checklist to incorporate CLAB stuff
13. Hawkes Bay DHB Weekly team meetings and get another team involved in the ICU
14. Counties Manukau DHB Investigate maintenance bundle for anaesthetists for burns patients, and for wards getting patients responsible for their lines (it's your line!!)
15. Canterbury DHB Get Naked! And look at compliance within theatres and CT, etc., High risk patient and Chlorex dressing
16. Capital & Coast DHB Involve relatives – use relative dashboard – engage in the journey to reduce CLAB
17. Waikato DHB Lab information system generated all hospital wide bacteremia lists
18 Auckland DHB Formalize process for investigating a CLAB, transparent and open

2. The "naked unit" an initiative that has been rolled out at Middlemore Hospital and presented by Catherine Hocking proved to be extremely helpful in terms of a creative positive way of increasing hand hygiene compliance. There was a big demand from the participants for this presentation and the intention was to go back to the units and implement a similar concept.

3. The roll out challenges presented by Dr Mary Seddon were well received and created a lot of dialogue and interaction. It also provided the teams with insights that would help them avoid some of the challenges. The roll out checklist that has been developed was shared with the group.

4. The Gaps presentation by Dr Shawn Sturland reiterated the benefits of the collaborative methodology and once again inspired participants and great provocation, he encouraged participants to "go out there and find the CLAB". Shawn encouraged teams to look for "near misses" and to be on the lookout for opportunities to improve the system.

5. The presentation by Dr Chris Manasell incorporating the guidelines for blood cultures and the process to follow once a positive BSI has been identified were well received and is an area that has been highlighted to follow up on at our Regional Meetings to be held in July. We would aim as a collaborative to ensure that we have the minimum requirements as demonstrated to be in place.

6. Some local DHB highlights included:

- Northland getting the patients on board with their "hand hygiene"
- Tairawhiti DHB demonstrating the challenges inherent in a small DHB and how these have been overcome
- Auckland CVICU reached 100 days CLAB free late May 2012
- Auckland PICU on track to reach 100 days CLAB free by mid June 2012
- Auckland DCCM making good progress toward 100 days CLAB free
- Whangarei ICU - 430 days CLAB free at 19 April
- Tauranga ICU - 730 CLAB free days at 18 May
- Hawkes Bay ICU - 365 days CLAB free as at 11 May
- ZERO CLAB reported nationally for the months of April and May
- A patient transferred from Auckland DHB had a central line with an up to date insertion bundle and maintenance bundle checklist in place which negated the need to remove the central line and insert a new line. This was a great outcome for both the staff and the patient
- Able to collect monthly data on our key measures
- Middlemore, Canterbury and BOP have each developed a data base which is proving to be invaluable in the monitoring of the bundles and adding robustness to data collection processes

Thank you for your support and committeemen to making this programme succeed. Please don't hesitate to contact me if you have any queries and/or suggestions.