Collaborative to Prevent Central Line Associated Bacteraemia

Collaboration across three ICUs.

DHB: Auckland District Health Board

Team members: Elaine McCall, Helen Richardson, Susan Atherton, Markus Lang, Merilyn Beken, Sally Roberts, Mary De Almeida, David Buckley, Les Galler, Andrew McKee

Development of ADHB working group

Development of individual ICU multidisciplinary teams

Development of DHB working group

- *ICU nursing leads, Nurse Consultant Nurse Specialist and Nurse Educators.*
- *Infection Prevention and Control nurse, microbiology consultant and registrar*
- *Meet weekly*

Development of DHB steering group

- *ICU Clinical Directors and Nurse Managers, Northern clinical lead, senior management, quality, microbiology, anaesthesia representation.*
- *Meet 3 monthly*
- *Written report from working group*

Part of the Northern Region DHB programme

What Changes have you tested?

	Change Tested	Outcome
1	Compliance with EBP •Developed ADHB insertion and maintenance form •6 month review of forms	Insertion forms being used in all 3 ICUs Changes made in light of feedback received from users
2	Availability of appropriate equipment CVC Insertion pack •drape changes •Chloraprep swabs Paediatric insertion pack developed	All 3 ICUs using a dedicated CVC trolley Regional adult pack in use Paediatric pack in manufacturing process. ? Could be Regional or National
3	Data collection and analysis •Improve consistency of application of agreed definition • Reduce variation in practice of blood culture specimen collection	Clinician training on applying definition of CLAB Blood culture guidelines developed

L to R: Elaine McCall, Susan Atherton, Sally Roberts, Lourdes Noronha.

Most Successful PDSA Cycle

Clear process for data collection of central line days (tally method) and CLAB events established to ensure accuracy of reporting rate per 1,000 line days

Promotional resources developed

- Display of information for staff
  - Evidence based practice bundles
  - Measures of success – days between CLAB
- Display of information for public areas within unit

ARROW

Immediately before putting on sterile gown

Check the line packaging to see if the line is coated, e.g. chlorhexidine

This is the actual position as confirmed on the CXR

Hand write details or put product sticker here

Chlorprep Swabstick

Any non-sterile items such as the ultrasound probe need to be covered with a sterile guard

This should cover the patient from head to toe

If a sterile glove touches something unsterile the glove must be changed straight away

Yet to be identified for PICU

One site, one insertion

Remove the drape once the dressing is in place

Highlights and Lowlights

- CVICU reached 100 days CLAB free late May 2012
- PICU on track to reach 100 days CLAB free by mid June 2012
- DCCM making good progress toward 100 days CLAB free
- Visit by Associate Minister of Health and team from the Quality Commission

- Development of central database for ADHB slow
- IHI Data display for measures limited

L to R Andrew McKee, Assoc Min Jo Goodhew, Hon Alfred Ngaro (National Party MP), Suzanne, Dr Janice Wilson, CEO HQ&SC

Spread Planning

- Implementation of maintenance bundle within ICUs by end of July
- Anaesthesia have started to use the insertion bundle and becoming part of the programme
- Plan to spread insertion bundle to radiology followed by renal department (adult health) within next 6 months
- Implementation of maintenance bundle on adult and paediatric wards starting with high use areas first, e.g. Haematology, Renal within 12 months
- A major benefit of the ADHB 3 ICUs working together has led to a more robust ADHB collaborative and to the strengthening of the relationships between units.