PROJECT GOALS

REDUCING CLABSI

Our Goals:
- Achieve critical care CLABSI SIR of .457.
- Decrease overall number of CLABSI events house-wide.

National Call to Action:
- National patient safety goal (NPSG 07.04.01) requires implementation of best practice or evidence-based guidelines to prevent CLABSI for short and long-term central venous catheters including PICC's.
- October 1, 2008: CMS added hospital-acquired CLABSI to list of conditions that will not be eligible for reimbursement in alignment with National Quality Forum list of never events.

TOOLS FOR SUCCESS

ORGANIZATION AND TEAM

BAPTIST HEALTH LOUISVILLE: LOUISVILLE, KY

BAPTIST HEALTH LOUISVILLE CLABSI TEAM
Alice Scanlon
Holli Roberts
Pam Kayrouz
Denise Carter
Case Kichler
Connie Barker
Dona Mosier
Dara Nutt
Sharon Randolph
Melissa Fugate
Diana Huber

RESULTS

Critical Care Central Line Utilization

Med/Surg Central Line Utilization

RESULTS

NUMBER OF CLABSI EVENTS

LESSONS LEARNED

- Work with other facilities within your own system or state association to identify and disseminate best practices more quickly.
- Seek out formal process improvement and project management methodologies to create and hardwire change.
- Engage bedside staff to uncover root causes and create solutions.
- Stay the course, don’t give up! Zero harm is the ultimate goal!

SUSTAINABILITY AND SPREAD

- Incorporate a bundle compliance checklist into bedside shift reports.
- Engage unit leadership and bedside staff by having them participate in daily bundle compliance audits.
- Capitalize on data from root cause analyses.
- Share success stories at the unit, hospital and system level.
- Discuss CLABSI prevention strategies at daily unit huddle.

IMPROVEMENT STRATEGIES

- Provide house-wide education for nurses and physicians on central line bundle elements.
- Standardize central line insertion checklist across the hospital system.
- Add central line bundle education to new hire orientation.
- Complete daily audits of central line bundle compliance.
- Annually update provide education updates for nurses.
- Incorporate CLABSI goals into key leadership evaluations.
- Report days since last CLABSI at the unit level and at daily safety huddle.
- Engage unit leadership and bedside staff to participate in root cause analysis sessions for every CLABSI.

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AHA/HRET HEN 2.0

STORYBOARDS

Bedside Shift Report

Root Cause Analysis

Daily CLABSI Audit Tool