Learn From Defects Tool Worksheet: Central Line-Associated Bloodstream Infection (CLABSI)

This worksheet is designed to be used near the bedside and is the shortened version of the CLABSI Event Report Tool: Data for Event Analysis. This worksheet will help your team learn what happened, identify the factors that may have contributed to the CLABSI, and discuss how to reduce the risk of it happening again with a different person.

Date and Time: _____ **Name:** _____

Attendees: _____ **Medical Record Number:** _____

Date of Birth: _____

What Happened? In a brief description, document what happened from at least two different staff members. Infection control and nursing staff are recommended, but others on the team who can give clear descriptions of what happened can document as well.

Infection control:

Nursing:

Significant Comorbidities:

Patient Location: _____ **Date:** _____

Patient Age _____ **Sex:** Male Female

Where was the catheter inserted? _____ **Number of lumens:** _____

Type of line:

- ○ Nontunneled (other than dialysis)
- ○ Tunneled (other than dialysis)
- ○ Dialysis (tunneled)
- ○ Dialysis (nontunneled)
- ○ Peripherally inserted central catheter
- ○ Port

Insertion site: ◯Chest ◯Internal jugular ◯Subcutaneous ◯Femoral ◯Upper extremity

Other: _____

What is the indication for the line? (Select all that apply)

- ☐ Hemodynamic monitoring
- ☐ Poor venous access
- ☐ Long-term antibiotics
- ☐ Vesicants or irritant drugs
- ☐ Hemodialysis
- ☐ Chemotherapy
- ☐ Multiple incompatible fluids
- ☐ Other: _____

Why was the line accessed? (Select all that apply):

Lab draws ☐ Medication administration ☐ Intravenous fluid administration ☐

Total parenteral nutrition (TPN) Hemodialysis Other: _____

Why did the CLABSI happen? What factors contributed? Summarize what happened to cause the defect by answering the following questions. Select Yes, No, or Uncertain.

1)	Was the patient receiving TPN?	Yes ◯	No ◯	Uncertain ◯
2)	Were there any observed breaches of proper hand hygiene by anyone involved in line care for this?	Yes ◯	No ◯	Uncertain ◯
3)	Was line necessity assessed daily?	Yes ◯	No ◯	Uncertain ◯
4)	Was the dressing integrity difficult to maintain?	Yes ◯	No ◯	Uncertain ◯
5)	Was daily chlorhexidine gluconate bathing completed?	Yes ◯	No ◯	Uncertain ◯
6)	Was this line manipulated/used by any other staff besides unit's physician/nurses (e.g., anesthesia, radiology, etc.)?	Yes ◯	No ◯	Uncertain ◯
7)	Was this line used for blood draws? If yes, how frequently? _____	Yes ◯	No ◯	Uncertain ◯
8)	According to your institution's policy, was the tubing changed appropriately for the duration of the line?	Yes ◯	No ◯	Uncertain ◯
9)	Was the catheter occluded while the line was in place?	Yes ◯	No ◯	Uncertain ◯
	If yes, was total parenteral alimentation (TPA) used?	Yes ◯	No ◯	Uncertain ◯
10)	Was the blood culture drawn from this central line?	Yes ◯	No ◯	Uncertain ◯
11)	Was this line in place >7 days?	Yes ◯	No ◯	Uncertain ◯
12)	Anything else, patient factors or otherwise, that may have Contributed to the infection? If yes, describe briefly:	Yes ◯	No ◯	Uncertain ◯

What prevented it from worsening? In a brief description, identify actions that prevented the CLABSI from getting worse.

What can we do to reduce the risk of the CLABSI happening with a different person? What will the team do differently next time to prevent another CLABSI? Identify key takeaways from this worksheet and develop a clear next step.

Action Plan	Action Plan Owner	Targeted Date	Evaluation Plan: How will we know risk is reduced?

With whom shall we share our learning? (Communication Plan) Now that you have more information about how and why this CLABSI occurred, how will the action plan be communicated?

Who should know about it?	When should they know?	How will they know?	Followup Items: Who should share the information? Any feedback?

This form was originally created by Saint Joseph Mercy Health System and the Trinity Health system of providers. This revised version is provided in the AHRQ Toolkit for Preventing CLABSI and CAUTI in ICUs with permission.

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