AHRQ Safety Program for Intensive Care Units: Preventing CLABSI and CAUTI

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 Other:____________

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?	Yes	No	Uncertain
	If yes, how frequently? _________________			
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?	Yes	No	Uncertain
	If yes, describe briefly:			

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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