

Table 1. Catheter-associated bloodstream infection diagram

Case Review – Catheter Associated Bloodstream Infection

Review Date: _____

Present: _____

Patient:

MRN:

DOB:

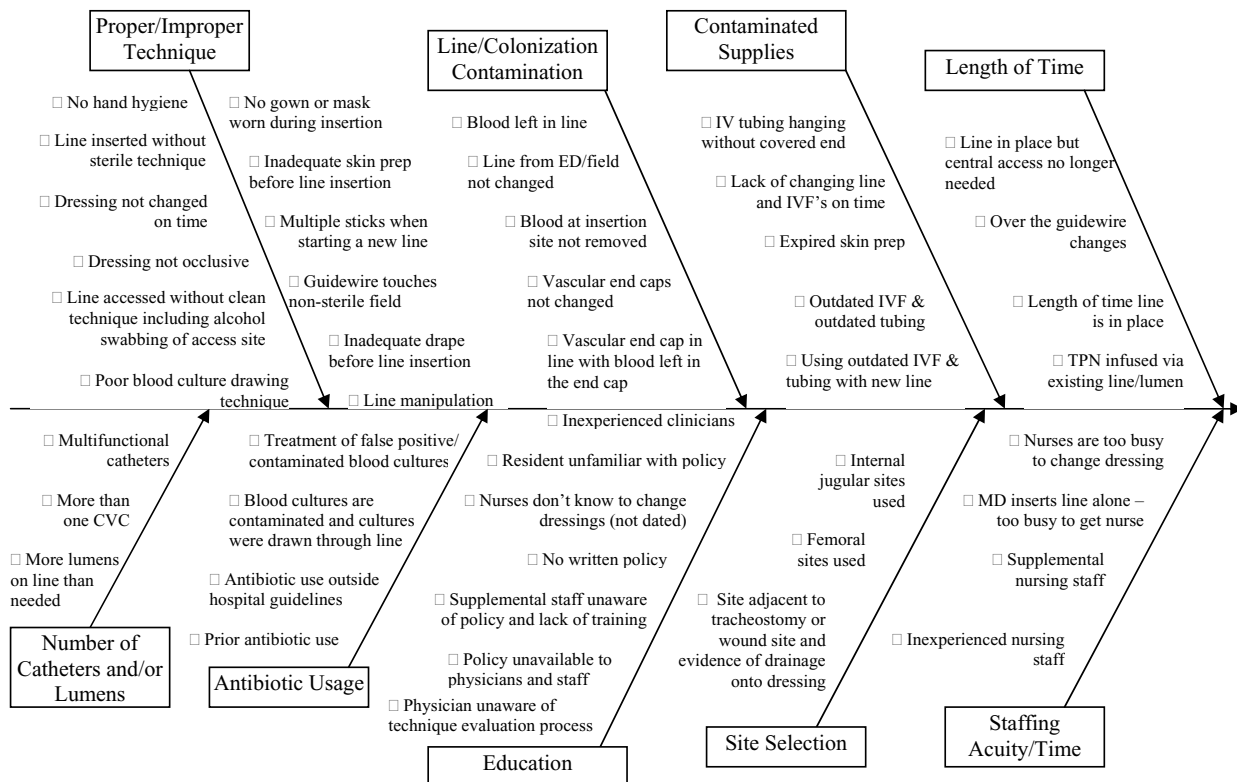
Adm:

Discharge:

Brief Summary:

Infection Criteria Met:

Probable Causes:



Conclusions / Actions to be Taken:

Central Venous Catheter Insertion Care Team Checklist

NOT A PERMANENT PART OF THE PATIENT RECORD

Purpose:	To work as a team to decrease patient harm from catheter-related blood stream infections.
When:	During all central venous or central arterial line insertions or re-wires.
By Whom:	Registered Nurse or Technician.
<ul style="list-style-type: none"> If there is an observed violation of infection prevention practices, <u>STOP LINE PLACEMENT IMMEDIATELY</u> and correct the violation. If there are any concerns, the Registered Nurse or Technician should contact the Department Manager or Chief Medical Officer directly. 	

- Today's date: _____ **Name of Physician/PA/RN Inserting:** _____
- Room number/location of insertion: _____
- Line type:

<input type="checkbox"/> Triple Lumen CVC	<input type="checkbox"/> Double Lumen CVC	<input type="checkbox"/> PICC
<input type="checkbox"/> Umbilical Catheter	<input type="checkbox"/> Temporary Hemodialysis Catheter	<input type="checkbox"/> Swan-Ganz
<input type="checkbox"/> Other _____		
- Line location:

<input type="checkbox"/> Subclavian	<input type="checkbox"/> Internal Jugular	<input type="checkbox"/> Femoral	<input type="checkbox"/> Other _____
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- Procedure:

<input type="checkbox"/> New line	<input type="checkbox"/> Rewire (culture catheter tip once removed)
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- Is the procedure:

<input type="checkbox"/> Elective	<input type="checkbox"/> Emergent
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- Time out performed?: ☐ Yes ☐ No (if no, why? _____)
- Consent obtained with signature, date, and time?: ☐ Yes ☐ No (if no, STOP and correct)
- Before the Procedure**, did the Physician (or IV Therapist):

	<u>Yes</u>	<u>No</u>	<u>Corrected</u>
Wash hands or use alcohol hand sanitizer immediately prior?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was hand hygiene directly observed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prep procedure site with Chloraprep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Prep procedure site with Betadine if infant < 2 months of age?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drape patient in sterile fashion to below the knees (CVC other than PICC).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* If PICC line placement, was the drape from the kit used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the Procedure, did the Physician (or IV Therapist) and Assistant:

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| Use sterile gloves? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Use hat, mask, and sterile gown? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Maintain a sterile field? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did all personnel assisting with procedure follow above precautions? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

After the Procedure:

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| Was a sterile dressing applied to the site? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|--------------------------|

If you answered "no" to any question, specify details below:

Name of person completing checklist: _____

Please return completed form to unit manager or designee. Then forward to Infection Prevention.